THE AMERICAN JOURNAL of OCCUPATIONAL THERAPY

OFFICIAL PUBLICATION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Vol. X, No. 6 1956 November-December

TABLE *of* CONTENTS

ARTICLES

DIVISIONS

FEATURES

The American Journal of Occupational Therapy

The Official Publication of the

American Occupational Therapy Association

Editorial Office: 3514 N. Oakland Ave.
Milwaukee 11, Wis.

Correspondence relating to editorial matters should be sent to *The American Journal of Occupational Therapy*, 3514 N. Oakland Ave., Milwaukee 11, Wis. Only original contributions should be submitted for publication in the Journal and if accepted, may not be published elsewhere without permission.

Opinions and statements expressed in the magazine are those of the authors of articles and are not to be considered as representing the views of the American Occupational Therapy Association.

Manuscripts should be typewritten, double spaced, with liberal margins and submitted in duplicate. References should be listed at the end of the article and not as footnotes.

Illustrations may be included. Photographs should be glossy prints 3" x 5" or larger. Drawings must be drawn and lettered in India ink on heavy paper.

Correspondence relating to subscriptions should be sent to the American Occupational Therapy Association, 250 West 57th Street, New York 19, N. Y. Change of address notices should include the old as well as the new address, postal zone, and should be mailed six weeks in advance of publication date.

The Journal is published bimonthly on the 10th of February, April, June, August, October and December.

Subscription price to members included in yearly fees; to non-members $5.00 a year domestic, $5.50 foreign. Single issues, $1.00.

Correspondence relating to advertising should be sent to the editorial office. Classified advertising accepted only for job opportunities or positions wanted.

THE AMERICAN JOURNAL
of
OCCUPATIONAL THERAPY
Official Publication of the American Occupational Therapy Association

November-December 1956 Vol. X, No. 6

THE AOTA REGISTRATION EXAMINATION
Past, Present and Future

(A 10-Year Progress Report)

HYMAN BRANDT, Ph.D.

ORIGIN AND DEVELOPMENT

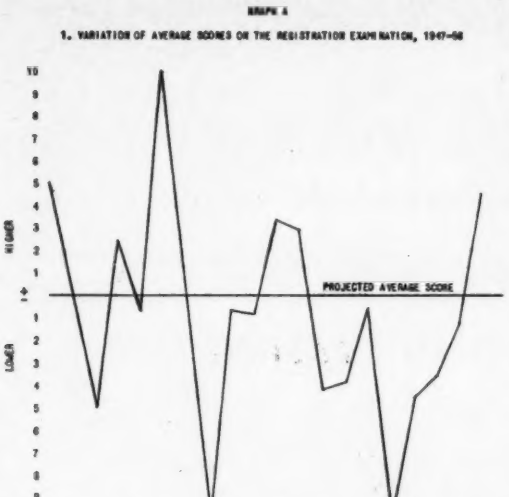
In October, 1946, plans were drawn to construct an objective, qualifying examination in occupational therapy. The examination was designed to accomplish the following purpose: to measure the extent of a student's preparation and understanding of the basic knowledges, skills, techniques, methods and procedures required for successful clinical performance as a registered occupational therapist. It was also to be geared at a specific level: the testing of information gained through graduation from a school of occupational therapy, and experience obtained through the required student affiliations in clinical centers. Since variations in curricular emphases and instructional patterns could, and did, exist in the schools, the registration examination would perform the important function of furnishing a common base for the measurement of the relative achievement of each of the graduates of existing and future schools of occupational therapy.

The accomplishment of the above objectives called for the establishment of a set of specific guide lines. The most important principle was the development of a common core of examination content which would insure an *equal opportunity* for each student regardless of where he had undergone his academic and clinical training. Equality of exposure must not be confused with equality of mastery of the content. The precise point is that differences in mastery are truly measured only when equality of opportunity for mastery can be demonstrated.

The common content was obtained by an analysis of the occupational therapy curriculum. Each school and student affiliation center was asked to submit course outlines, references, and every type of curricular device used. Eighteen subject matter specialists (assigned to cerebral palsy, psychiatry, woodworking, etc.) collated the materials and built "master" topical outlines for their respective areas. The total practice of occupational therapy was divided among thirty-five areas and assigned to the eighteen specialists meeting as a group. It was recognized that a master outline could contain elements not commonly or presently taught. Inclusion of such would, however, serve as a means of furthering curricular revision and development to expand the service of the profession to the medical field. From these master outlines containing complete information on all specialties, test outlines were developed. The test outlines emphasized those aspects of each area which were both common clinical practice and those commonly taught in the schools.

Having secured relevancy through the development of a common content for the examination, the next step was to insure comprehensiveness of coverage. This required the experts to decide what percentages of the total examination should be assigned to each of the thirty-five areas to secure a balanced examination which would reflect current practice and training. Factors influencing this decision were: The American Medical Association's *Essentials of an Acceptable School of Occupational Therapy*, the number of hours devoted to the course by each school, the frequency and extent to which each subject was augmented in the clinical center and utilized in the practice of occupational therapy. The schools have been informed of the relative numbers of questions assigned to the various areas in special

*Educational Research Consultant, American Occupational Therapy Association.

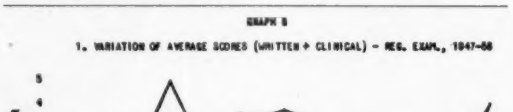


frequency reports rendered to them. The original test construction group further decided that 300 multiple-choice items would insure adequate and reliable coverage of the majority of the thirty-five areas.

The concept of appropriate content coverage was carried a step further by appropriately distributing the number of items assigned to a given area so as to reflect the desired emphasis in current and common training and practice. These included questions relating to science background, clinical conditions, and the application of occupational therapy to such conditions. In the case of creative and manual arts, knowledge of such and their therapeutic applications were weighed as was deemed appropriate. This item allocation was last carefully reviewed and adjusted in 1950. Present and future curriculum studies will furnish the basis for further item reallocation.

The subject of item writing is worthy of a separate article. Suffice it to say that the assembled group of subject matter specialists received a course in the principles of item writing, especially the writing of multiple-choice questions. The primary objective of a multiple-choice question is to achieve *brevity consistent with clarity.* This requires the item writer to pose a central, definite problem; to remove unnecessary verbiage and to refrain from superfluous instructions. Adherence to this principle permits the testing of an individual's knowledge and application of said knowledge rather than speed of reading or ability to fathom the item writer's thoughts.

Variation in difficulty level (the ability of students to secure the right answer) was achieved through developing questions which called for interpretation, comparison, discrimination, evaluation and application as well as recognition and recall of pertinent facts. Further variation is obtained by varying the format of the question.



In addition to regular multiple choice which asks the student what is the correct information, reverse and preferred multiple-choice are commonly used in the registration examination. "Reverse" requires a student to tell what is wrong; "preferred" utilizes the comparative method and asks the student to choose the best or worst of a group of given solutions to a problem.

The formal layout of the 300 test items also embodies several important principles. The examination is divided into two parts, given in two separate sittings. Each part covers all the areas of occupational therapy equally and the items are ordered in such a manner as to secure representation of the entire field of occupational therapy in each successive tenth (30 items) of the examination. This was done to secure a measure of the student's knowledge of all the areas of occupational therapy regardless of where he stopped when time was called. The cycle of 30 items is

sufficiently long to insure adequate mental set and to discourage skipping.

Time to answer the questions was set to reduce the element of speed to a minimum. With rare exceptions, everyone finishes all the questions and has time to read them carefully and to review them, if necessary. Those for whom English is not a native tongue are given additional time to remove any possibility of penalizing them. The registration examination is a power test permitting an individual to display his knowledge, and application of this knowledge, at his own pace.

Those of you who have taken the examination know that a separate answer sheet is used for ease of administration and scoring. The proctor also uses a specially prepared manual (relating to the handling of test booklets, answer sheets, timing, answering examinees' questions, etc.) which permits of no deviation. This is necessary so that each student will take the test under the same conditions. Naturally, all possible measures have been taken to insure the security of the examination.

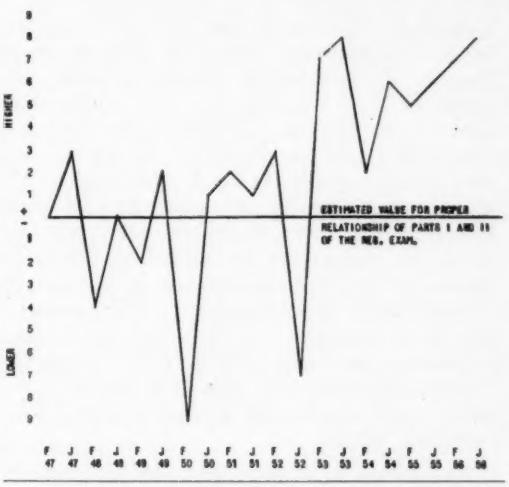
CURRENT STATUS

Registration examination data. The AOTA registration examination has been administered twenty times in the past ten years to approximately 4600 students. A little more than 200 of these have retaken the examination one or more times. The average score for each examination has not varied more than 5 to 10 points, about the average score which was originally projected as furnishing the best possible spread of scores for differentiating the relative abilities of future practicing therapists (see Graph A). The statistical measure for this spread has remained just as consistent (see Graph A). This constancy of achievement has reflected the foresight and skill of the original specialists in shaping the content of the occupational therapy curriculum into a reliable and accurate examination. This consistency has also enabled the registration committee to set a cutting score (pass vs. fail) after each test administration in terms of each specific score distribution (see Graph B). The variation in cutting score for the twenty administrations has been less than three points. The shape of these score distributions has so closely approximated the normal probability curve that the results can be accurately reported to the schools in terms of decile scores. These indicate in which tenth of the distribution each student falls.

The two parts of the examination have also demonstrated considerable consistency of performance throughout successive test administrations (see Graph C). The relationship between the two parts has remained very high but not so high as to ever consider one part as duplicative

GRAPH C

VARIATION IN SIZE OF CORRELATION COEFFICIENTS – PARTS I AND II, REG. EXAM., 1947–56



of the other. Rather have they demonstrated that a student's knowledge and application of the knowledge can be just as effectively measured on each half of the examination.

The setting of cutting scores is a matter of policy. It is an important aspect of the planning of the overall difficulty level of any examination. The registration examination was never conceived as an elimination contest nor as a rigid barrier against future practice in the field. It has sought rather to measure minimal achievement and to make certain that each student has an adequate background for the competent practice of occupational therapy. Thus a small percentage of those earning the lowest scores have been failed each time. The scores of these students have been so low that one is drawn to the conclusion that they have neither absorbed, nor seem able to successfully utilize, whatever information and skills have been taught them. This belief has been fortified by the fact that the percentage of failure of those retaking the exam has been approximately seven times the failure rate of students taking the exam for the first time.

Another point which has already been noted is that a cutting score is set each time solely in terms of the distribution for that examination. This removes any bias that might exist if a fixed cutting score were adhered to each time. Thus a large shift (which has never taken place) in the difficulty level of items or the relative degree of preparation of the students might readily penalize some students (favorably or unfavorably) if a specific norm were set. Again the overall stability of our questions and of our student populations has given us a freedom from bias in setting a cutting score after each test administra-

tion. Each time only those students who have exhibited an inability to meet minimal standards have been eliminated.

In fact, the basis for the stability of our successive sets of exam scores has been the maintenance of continuously satisfactory item difficulties and item discrimination indices. The registration committee and the education office have been ever vigilant in its review of the test item data subsequent to each test administration. The analyses of the pattern of response to each of the four choices of each of the test items have enabled the registration committee to check the desirability of retaining, revising or deleting the question from the examination. This considered and time-consuming creative effort has enabled the registration examination to retain its vital and effective function—the measurement of a student's preparation for the clinical practice of occupational therapy.

In addition to a thorough evaluation of the internal workings of the registration examination, as has been discussed above, the relationship of performance on the examination to other achievement and ability measures was assessed during the first few years of this program while funds were available from the Kellogg Foundation. The first study concerned itself with the relationship of examination achievement to academic grades (the classic study in educational research). Difficulty was encountered in making the most effective use of the grades submitted by the schools of occupational therapy. Various types of grading practices (numerical, letter, or other) as well as varying standards (cut-off points and ranges) for assigning specific letter grades were employed. Thus, adjustments had to be made to fit all special types of grading into a single numerical code applicable to all schools. Such an attempt inevitably introduced a restriction in range of grade scores which would materially affect the size of the correlation coefficients to be obtained when registration examination scores were correlated with the total grades or with each one of the five divisions set up by the American Medical Association's *Essentials* (biological sciences, clinical subjects, social sciences, occupational therapy theory and therapeutic media). The results obtained, however, warranted the use of a national registration examination as a common measuring rod for the graduates of all schools of occupational therapy.

Attempts were also made to see whether the registration examination set a premium on native ability or vocabulary comprehension. As far as mental ability measures were concerned, we met a virtual impasse. Variations in the number and types of ability measures current in the schools prohibited the use of a common denominator. The study had to be abandoned. Ten years have passed and several schools now have sufficient numbers of graduates who have taken the registration examination. It would now be possible for these schools to secure this extremely valuable information.

As a possible substitute, the Michigan Vocabulary Test was administered one time along with the registration examination. The specialized vocabularies did not show a particularly good relationship, except the one relating to the biological sciences. No one section of the Michigan Vocabulary Test is long enough to be reliable as an indicator of ability in a given vocabulary area. The question of how much the native ability of the student and/or the instructional skills of the staff of that student's school contribute separately towards the students' performance on the registration examination is still an intriguing one. It is deserving of further study whenever sufficient funds become available.

As everyone knows, the registration procedure is divided into two phases: the written examination which we have covered in detail thus far; and the evaluation of a student's performance in his clinical affiliations by his supervising therapists. A few tentative studies have been made to assess their relative contribution to the registration procedure. Students are permitted to take the written examination one month prior to their completion of all clinical affiliations. Comparisons of the performance of such students with the performance of those students who have completed all their affiliations have indicated that the relative standings of the former, as a group, are not impaired by the absence of one month of clinical affiliations.

In the early stages, the relationship between clinical evaluations and scores on the written examination were studied. These reflected the usual lack of correlation between an evaluation geared to stress interpersonal relations with a measure designed to reflect a student's skills and knowledge and their application in clinical practice. Both are essential to assess a person's competency in occupational therapy. Thus, the original planning group incorporated these two phases into the formal registration procedure. A great deal of thought and effort have gone into the development of an objective evaluation of student performance in clinical affiliations. The new report forms have sought to achieve an assessment of the qualities of the student—the operation of his personality in the clinical setting in which he is applying the knowledge gained in the classroom. What is necessary is a measure which will yield greater degrees and more de-

grees of differentiation among students so that an evaluation of student affiliations will be just as effective as the present written examination in spreading the students along an achievement continuum. Here is another avenue worthy of continued exploration.

The registration examination and the occupational therapy curriculum. As has already been stated, the original planning of the examination called for an analysis of the then available curricula of the schools of occupational therapy. Stimulation arising from this venture resulted in the publication of a *Curriculum Guide* by the Association in 1950. Immediately upon its publication, the registration committee undertook a reexamination of the item content and the item allocation of the examination. Thus the examination seeks to constantly reflect the curriculum standards set by the American Medical Association as the essentials for an occupational therapy curriculum. As proposed curriculum surveys are initiated and their results tabulated and formulated, the registration committee will exert every endeavor to incorporate both changes in specific content and changes in emphasis within the total curriculum in future examinations.

Not only does the registration examination seek to keep pace with curriculum development but it also serves to keep the schools acquainted with how well their graduates are absorbing the current curriculum. Special analyses are made of the performance of the students of each school on the written examination. These include the actual achievement scores and the relative standing of each school on a series of test administrations. Up to 1956, data were reported back to the schools every two years; from 1956 on, reports will be rendered annually.

The most important data furnished the schools relate to the percentage of errors made by their students in each of fifteen major subject matter areas in the examination. These area analyses can be utilized by the schools to investigate their situation where weaknesses are disclosed and to discuss with their instructional staffs how improvements might best be made. Some schools have found these data so valuable and informative that they have asked for, and received, extended and more detailed analyses in specific areas. These analyses have sought to differentiate between knowledge of basic science and the application of occupational therapy to specific clinical conditions within that area.

Another vital service which has been rendered is the preparation of similar material on an individual basis for those students who have failed the examination. Such a summary of exhibited weaknesses should guide the student in his preparation for a second attempt. The information is furnished only on request. A student may attempt the examination three times.

The registration examination and the student affiliation centers. The registration examination has exerted a direct and specific influence on the student affiliation centers from the very origin of the project. As has been indicated previously, not only schools but student affiliation centers were requested to contribute all curricular materials utilized toward the development of the master outlines. As with the *Curriculum Guide*, the directors of student affiliations utilized the materials to help develop the *Director's Guide*. The greatest impetus was rendered, however, with respect to the development of an objective evaluation report on student performance in clinical affiliations. This arose from the simple fact that a specific weight (20%) was assigned to this evaluation as a part of the total registration procedure.

When the written examination was introduced, there was in existence an evaluation form which listed thirty traits. These traits were not defined but were rated on the basis of five divisions—superior through poor (failure). There was no rater's guide. The first steps undertaken to increase the objectivity of this form was the utilization of a 15-point scale and an interpretational key describing the qualities related to each point of the scale. The realization that this report form overemphasized personal traits to the exclusion of most everything else led to the development of a new form, the clinical training report, in 1950. Several important advances were made. Application of skills and knowledge as well as interpersonal relations were incorporated in the clinical training report. The number of individual traits was reduced to eleven and the rating scale to nine divisions by a special Association committee which made a thorough analysis of the demands made upon a student in his clinical affiliations. Each of the eleven traits were defined in the above terms so that each supervisor would be rating the same element with a minimum of personal interpretation of the particular meaning of the trait. Only the extent to which a student accomplished the demands would involve the judgment and experience of the evaluator. The clinical training report form suffered under an initial handicap from which it apparently never recovered. Inadvertently, the scale score settings reaching a maximum of 99 (11x9), furnished an impression of a per cent scale. This led to many dealing with it as if it were a customary per cent scale used to convert letter grades in schools. As a matter of fact, some schools required the conversion of the clinical training report scores into letter grades. Scores were thus pushed towards

the upper end of the scale and differentiation in the relative standings of students became nebulous.

The desire to improve the clinical training report was enhanced by the introduction of an experimental evaluation form, the performance report form, which student affiliation supervisors were required to complete in the experimental validation of the career inventory, a student selection instrument. Again, a special Association committee was instrumental in developing a special affiliation model, the report of performance in student affiliations. This again embodied several advances over the clinical training report. Most important were the introduction of two parts to the evaluative process. Part I constitutes a detailed analysis of the behavior of a student across fourteen entities (both personal and professional characterstics). These are evaluated solely on a frequency of behavior basis as observed by the supervisor. Part II is a summary evaluation of six major components of this behavior in terms of the relative degree of competency of performance when compared or contrasted with other students in the same affiliation. A third part was added to help the school counsel with the student. The report of performance in student affiliations became the official form in 1955 and its behavior throughout that year and 1956 has been carefully studied and reviewed. A comprehensive report is in progress and will probably be released in the spring of 1957.

It is believed that sufficient progress can be made in obtaining a valid and objective evaluation report. This will enable the original planning committee to see one of its original goals accomplished: an increase in the weighting assigned to the clinical evaluation in the registration procedure.

Maintenance of the registration examination. The maintenance of the stability and discriminating power of the registration examination is a task which has involved the devoted labors of many within the Association. The two executive directors and the four educational secretaries who have held office during the past ten years and the assistant in the education office during the past year have all been deeply involved in this maintenance procedure. The registration committee which has had a total of twenty-five members over the past ten years has borne the major responsibility for this task. The accomplishment of this mission would not have been possible without the able cooperation of many O.T.R.'s who have rendered valuable service by writing items which could be used to replace questions which weren't behaving well in the examination.

Maintenance of any examination which is to be used over a period of years is an absolute necessity. Items do not always behave the way one expects. From time to time, the students find some items too easy, others too difficult, and still others somewhat confusing so that their response patterns are quite out of line with the original keying. Item repair is based upon the response patterns of the entire group of students taking a particular examination. For the registration examination, a complete alternate item analysis is made to insure that every choice is working properly. The data (response patterns) are based on appropriate numbers of students who score the highest on the total examination and of those who score the lowest. Difficulty (% passing) and discrimination (the power of the item to differentiate between the high and the low scorers) indices are obtained for each item. All these data are carefully reviewed by the registration committee subsequent to each test administration and decisions are then reached as to retention of the item; revision, if necessary and possible; and deletion, if something is radically wrong with the item. While only a small number of items are deleted from each part, it is sufficient to require the presence of a good and extensive pool of items to replace the deleted ones. One must remember that item replacement involves retention of item content and area allocation in the examination. It is decidedly a matter of selecting a new item which appears to be more likely to measure the content already deemed essential for the registration examination.

Thus the registration committee and its consultants have another very vital function to perform: the review, editing and acceptance of new items submitted by the item writers for the replacement pool. The need for writing items cannot be expressed too strongly. It will provide the basis for assuring the continued quality of the registration examination if a continuous, exerted effort to produce items is maintained.

A pool of 600 to a 1,000 items (spread across 35 subject matter areas) is required for another reason: the development of one or more new parts to the registration examination. At present we have three parts which permit of only three combinations of two parts for the total examination. The addition of one more part would raise our available combination to *six*. The addition of two more parts would increase these combinations to *ten*. The availability of one or two more parts would spread and lessen the burden of revision and replacement over the ensuing years. The accomplishment of any of the above would be so great a gain for occupational therapy as to spark a vigorous item drive for the future.

THE REGISTRATION EXAMINATION AND THE FUTURE

As we look to the next decade, we are convinced that maintenance of educational standards and their appraisal by means of the registration procedure will require that we concentrate our efforts in several directions. Some of them have become apparent already as a result of our previous discussion. They will, however, bear reiteration at this point.

1. How can the content of the registration examination best continue to reflect the current school curricula? As curriculum surveys and institute workshops translate their findings and deliberations into changes in emphasis and newer curriculum content, it will be necessary for the registration committee to review the item content and area allocation of the registration examination. Such adjustments are inevitable with the ordinary passage of years. There has been, and there will continue to be, so much activity and change with respect to the occupational therapy curriculum that a review of the registration examination should take place in the near future.

2. How can the registration examination best maintain or improve its present level of item effectiveness? The registration examination must have a large pool of items suitably representative of all areas of occupational therapy. They must be properly written to insure an appropriate spread of difficulty level and discriminating power. These requirements call for the initiation of as many potential item writers as possible into the principles and techniques of multiple-choice item writing. The author believes that this can best be accomplished by having groups of people get together and share their experiences in writing items. Pertinent manuals have been written for the education office for the use of item writers where face-to-face contact has not been possible, mainly for lack of funds.

3. How can the evaluation phase of the registration procedure be strengthened? All the members of the Association have been exceedingly keen on having the clinical evaluation of students achieve a greater weighting in the total registration procedure. They have felt justifiably that student clinical practice is a fair barometer of future practice as a registered therapist. The drawback thus far has been the difficulty in obtaining a valid and objective evaluation of student practice. The education office has gone through a lengthy period of developing various forms. The latest form—the report of performance in student affiliations—while it does not furnish all the answers, is well on its way to overcoming the aforementioned difficulty. A thorough review of the behavior of the report of performance in student affiliations over the past two years should aid considerably in deciding whether an evaluation has been obtained which would warrant increasing the weighting of this phase of the registration procedure.

4. How can our measurement of the content of a student's academic preparation and clinical practice be improved? Some of the data arising out of item analyses of the registration examination have given rise to thoughts that the multiple-choice, written test item may not be the most effective means of measuring student achievement in certain content areas of the examination. The area which has caused the greatest concern has been that of creative and manual arts, especially since some therapeutic activities are, of necessity, briefly covered in the examination.

It has been suggested that ways and means be found to evaluate a student's knowledge of therapeutic activities in his clinical affiliations. Development of this type of evaluation will require a carefully planned study of the manner in which students learn and apply their knowledge of therapeutic activities in the clinical affiliation. This project will have to be just as thoroughgoing in its planning and development as the original planning for the present registration examination. The launching of such a project is also dependent on the availability of funds from an outside source.

Not quite so radical a departure from the present registration examination structure is a suggestion that a few areas of the examination involving occupational therapy theory, application of occupational therapy theory to clinical conditions, and organization and administration be tested by another type of item. The thought is that the utilization of situations involving a series of judgmental items might offer a better means of discovering a student's knowledge and ability to apply what he knows. Again a careful analysis will have to be made to insure securing situations which are standard, comprehensive and non-controversial in terms of accepted principles and techniques of operation and conduct. The expense of undertaking this project is considerably less than the one relating to therapeutic media. It is, nevertheless, beyond the current budget of the education office.

ACKNOWLEDGEMENTS

All of the above are extensions of the original planning and excellent thinking of the group who built the original registration examination in that strenuous Christmas-New Year two-week span in 1946-47. They created an examination which has continued to ably serve the profession of occupational therapy for ten years as a means of determining the qualifications of an occupational

(*Continued on page* 309)

An Abstract of
PRINCIPLES OF SUPERVISION*

BEATRICE WHITCOMB, Major, AMSC**

INTRODUCTION—MODERN CONCEPT OF SUPERVISION

Administration is the performance of the executive duties of an institution or business. The word "coordination" is often used in connection with administration and "consultation" with supervision. The structure of any organization must reflect not only the logic of the work to be done, but also the special aptitudes and characteristics of the individuals taking part since it is the people that make the accomplishment of the work possible. Because of the intimate relationship and overlap, the old distinctions between administration and supervision disappear within a modern functional program. Since coordination of facilities and activities and overseeing are interrelated responsibilities of the head physical and occupational therapist, no effort will be made to distinguish between the functions of administration and supervision during the following discussion.

THE PERSONALITY AND PHILOSOPHY OF THE LEADER

Most of the research until recently has concerned itself with the characteristics of the leaders. Many authorities have given us lists of traits which leaders supposedly have but followers do not have. A review of these studies shows that there are no general leadership traits which are common to all great leaders, and that there is surprisingly little agreement among executives and educators on what makes a good administrator. One report based on a study of 75 companies and 20,000 employees reveals that men who are doing first-class administrative jobs have in common the following five basic qualities:

1. *Intellectual competence.* This quality includes the capacity to acquire knowledge, the ability to make decisions and the courage to make them stick. This quality also implies a quiet type of self confidence, an open mindedness and an ability to see the interrelationships of facts in a given situation and to cope with the new.

2. *Emotional stability.* This trait depends on consistency within an acceptable pattern of behavior so the staff will know what to expect of the supervisor.

3. *Skill in human relations.* The behavior of the leader is contagious. As the supervisor is democratic, considerate, appreciative, frank and modest, so will his staff follow in his footsteps in dealing with others.

4. *Ability to understand behavior in oneself and others.* On this understanding is based the administrator's ability to get the best results from others. Sensitivity to people will prevent categorizing and labeling staff members as one or another type.

5. *Ability to organize and direct.* This trait includes the ability to plan and initiate and to delegate responsibility. The leader with this quality is able to help other members of his group reconcile their competitive ambitions and work as a team toward a common goal. When this quality is present, satisfaction will come from developing able assistants rather than from doing the work himself.

One author recently has grouped the skills necessary for an effective administrator in a simple and practical manner as follows:

a. *Technical skill.* This involves specialized knowledge and analytical ability within a given specialty and the ability to use the tools and techniques of that particular discipline. This skill is indispensable to efficient operation. As the administrator moves further from the actual physical operation, the need for technical skill becomes less important provided he has skilled subordinates who can help solve their own problems.

b. *Human skill.* This is the ability to build cooperative effort within the team he leads and is demonstrated in the way the supervisor perceives his supervisors, equals and subordinates and reacts toward them. Human skill, the ability to work with others, is essential to effective administration at every level.

c. *Conceptual skill.* As used here, this skill includes the ability to see the enterprise as a whole, to recognize over-all relationships and the significance of each part to the whole. It is the vision and creativity behind the organization and its unifying and coordinating ingredient. Recent research findings show that as we go higher and higher in the administrative echelons with the need for policy decisions and broad scale action, conceptual skill becomes the most important ability of all.

It is obvious that the purpose of supervision

*Lecture given at the course on administration offered by the Philadelphia School of Occupational Therapy under the sponsorship of the United States Office of Vocational Rehabilitation, Feb., 1956.

**Chief, AMSC Assignment Section, Office of the Surgeon General, Department of the Army, Washington.

varies with the situation. Among the aims of supervision in physical and occupational therapy are the improvement of patient care, more effective performance of personnel and better training of students. Good supervision sustains a unity of purpose and a coordination of effort contributing to the growth of all on the staff. A study of the usual type of situation in which the physical and occupational therapist must exercise his leadership would indicate the following list of leadership traits which, while not all-inclusive, contains those of paramount importance.

(1) *Technical mastery and thoroughness.*

(2) *Enthusiasm.*

(3) *Initiative.*

(4) *Knowledge and skill in the principles of learning, teaching and evaluation.*

(5) *An understanding of the principles of human behavior.* The supervisor must know what the individuals bring to their work situation in the way of attitudes, beliefs, skills and hopes; what the work is demanding of the individuals in the way of standards of performance, conduct and pressures; and what the resulting equilibrium is between the demands of the individual and the demands of the situation.

(6) *Friendliness, affection, and tact.*

(7) A good leader has *faith in people* and willingly demonstrates trust in them.

(8) *Integrity and fairness* are essential for confidence and good will within any group. The wise supervisor strives for objectivity in dealing with problems.

(9) *Emotional control* acts as a restraining influence over loss of courage, fear, worry, pride and prejudice. When conduct is guided by reason, the leader gains a sense of strength, proportion, purpose and direction.

(10) *A good leader has a sense of humility.* He asks questions and admits he does not know all the answers or has not done a good job, if such is the case. There is armor in humility since it saves frequent injury to pride. There is a close relationship between humility and security. A student or staff member will never hesitate to ask for help from a humble person.

An integral part of all the traits mentioned thus far and fundamental to successful personnel administration is the philosophy of the organization as expressed through its leaders. While there is often criticism that too much time is spent in philosophizing and too little in doing, it is a well known fact that the practice of supervision will never rise beyond the basic philosophy of the supervisor. Individuals in every kind of work want to be on a team motivated by high ideals and they usually respond with enthusiasm when they feel that their leaders are sincere and fair and that they are committed to a democratic philosophy. The modern leadership philosophy includes belief in the inherent soundness of group decisions with the knowledge that the most desirable results take place where individuals share in the planning of their own activities and in the solving of their own problems. Finally, it recognizes that the good administrator is a democratic leader rather than an authoritarian type of supervisor.

WHAT WORKERS WANT FROM THEIR JOBS

We are all well aware of the basic needs which must be met if people are to be satisfied in their work situations and are to move along the line of success rather than failure. While psychology, social science and industrial literature constantly refer to these needs, there is a tendency to overlook them perhaps because of their very simplicity. While different authors describe them differently, the needs are the same.

E. H. Van Delden gives us the following guide to understanding human relations problems: (1) *All of us resent domination.* The technique of domination is outmoded since it has been found that workers put forth their best efforts only if they respect their supervisor and believe him to be reasonable and sincere. (2) *We are more likely to agree with those whom we like personally.* The way to get to like people is to know and understand them. Supervisors should learn to know and talk with all their staff members. Impersonality is the cardinal sin in dealing with human beings. (3) *We are inherent sentimentalists* and who ever punctures our sentimental fantasy is indeed an enemy. This emotionalism extends to such intangible values as security, seniority, safety, separations, retirement and grievances. Positive sentimental values may be built up by thinking and actions that indicate regard for human values. (4) *All of us want to feel important.* Lack of recognition can embitter man. The greatest cruelty is to be ignored or treated as one of an impersonal group. Every individual has a tremendous belief in his own honesty, and antagonism will be aroused whenever his integrity is questioned. (5) *We all want to be in the know.* What we do not know we tend to fear. It is a safe rule never to overestimate anyone's knowledge or underestimate his intelligence. Rumor grows in the absence of fact. Workers want to know where they stand and why. (6) *We like to win over obstacles.* We like to feel we are justly entitled to everything we receive, therefore paternalism and benevolent despotism leave much

to be desired. (7) *We are all different.* The sort of treatment you might want for yourself could be all wrong for the worker with whom you are dealing. It is necessary to put yourself in his place instead of blindly following the Golden Rule. (8) *People resent being rushed.* We must recognize the inevitability of gradualness. Ideas must be planted and given a chance to develop naturally. Timing is important in all human dealings. (9) *We try to obtain all we can within reason* and will sometimes become unreasonable if we feel we are not getting a square deal. Workers are inherently fair if given a chance to understand the situation thoroughly.

SUPERVISORY PROCEDURES

So far we have discussed the modern concept of supervision, supervisory qualifications and what the workers want from their jobs. The remainder of the discussion will concern some supervisory techniques or procedures deemed necessary for the physical and occupational therapist.

A. *Communication and consultation.* Communication has rightly been called the "soul of an organization" and it is probably the one most important single tool a supervisor can possess. The success of any enterprise depends on the thinking, motivations, ideas and complexes of all members of the organization. Provision should be made for the establishment of lines of communication between individuals on each level and between the various levels of the organization. This may take the form of regular group meetings to give out the necessary information or to discuss the plan together.

Communication is a matter of attitude as well as talk. The supervisor must be willing to listen to others and by his gestures and expression show tolerance for the ideas of others. It must be remembered that all people concerned in the project are important and the truly great leader sincerely believes in and operates on this policy. There is no substitute for firsthand communication.

The leader must be positive and decisive in speech. He never should "talk down" to his group since people quickly sense this and resent it. Language must be appropriate to the situation. It is constantly demonstrated that facts traveling over an open communication line can reduce tension.

B. *Participation.* The leader must train coworkers as a team. Followers who feel they are necessary to a goal bigger than their own desires and abilities take pride in their tasks. No leader can expect to evolve all the ideas he needs. Active deliberation with the group to evolve new ideas is essential to progressive operation.

Ordinarily those on the supervisory level have sufficient responsibility, comprehension and personal status to feel like participants. The real problem is to raise the participant-quotient of the average staff worker. Experience constantly proves that friendly, unaffected social relations on the job, opportunities for consultation on personal problems, open group discussion and the restraining of leaders in accordance with democratic standards are indispensable conditions, but are effective only in proportion to the degree that workers participate in establishing and maintaining these standards.

Again, in the problem of gaining participation, the basic philosophy of the supervisor is of importance. He must have faith that people have much more ability and constructive energy than usually comes out and he will see that successful achievement lies in pooled experiences. Although it sometimes takes more time and patience, he must see the value of unanimous decision or "consensus" rather than autocratic decision.

Some practical suggestions on how to increase participation are: (1) Organize, in so far as possible, the program around problems of personnel starting with their present situation, (2) Encourage individuals to make suggestions, (3) Establish a permissive atmosphere, (4) Give recognition to suggestions, (5) Put practical suggestions into action immediately, (6) Encourage less talking by yourself and more by your coworkers, (7) Assign responsibilities to all members of the department, (8) Identify problems and interests of the group with the organization as a whole, and (9) Say "we" and "our" rather than "I" and "mine."

C. *Assumption and delegation of responsibility.* The leader must seek responsibility for himself and develop a sense of responsibility among his co-workers. It is inherent in our nature to feel a personal interest and responsibility for the job we do. Frequently what an individual accomplishes is in direct relation to what others expect him to accomplish. The leader who is continually preparing himself for added responsibility does not cling to those responsibilities he already has. Only by sharing existing responsibilities with co-workers can the leader gain additional ones.

Responsibility should always be accompanied by authority and it should be accepted fully or not at all. The supervisor may delegate responsibilities but they can not be relinquished. He must take responsibility for his own actions and for the actions of those under his supervision. The follower who feels that his actions are backed by the leader is more willing to assume responsibility. It must be stressed that if supervisors want others to assume responsibility they must be sure that those to whom the responsibil-

ity is delegated also have the necessary authority for carrying out the task. The extent of the authority should be carefully defined.

Group members are willing to accept more responsibility when credit is given for past performance. There must be avoidance of giving an appearance of exploiting of staff members. Those already overburdened must not be imposed upon even though they appear to be the most capable. Finally, the assumption of responsibility is fostered where joint planning is encouraged and where recognition is given by the supervisor for outstanding contributions or for work well done.

D. *Giving directions or orders.* Each member of the staff should know as a result of good training what is expected and what performance standards are to be met. When a condition of planned operation exists, order giving is reduced to the minimum. Regardless of the degree to which the work is planned in advance, situations arise where the leader must issue instructions or requests. Order giving is an art. The following points are helpful in getting instructions executed in a cooperative manner: (1) Be clear. The result of a vague order is an error. (2) Be explicit. Let the worker know the limits of individual discretion in deciding the ways or means of doing the assignment. (3) Use your voice to good effect. Directions should be given in a natural voice, one without annoyance, fatigue or apology. (4) Phrase your requests courteously. The follower's point of view must always be considered. Most good executives precede requests with "don't you think we had better ....." or "will you please ....." or similar prefixes. Order giving requires good manners. (5) Give only a few instructions at a time. Too many things to be done at one time create confusion and bewilderment as to which is to be done first. Timing and spacing are important. (6) Try to minimize negative orders. Phrase requests in the positive where possible. (7) Try to avoid contradictory instructions. Where these must be given explain the reason. If you have been wrong admit and correct the error. (8) A word of thanks or commendation is always in good form.

E. *Giving reproof.* When he exposes the shortcomings of an individual, the supervisor is only the agent of an organized purpose. Therefore, he must offer the criticism in the most impersonal manner possible. If corrective advice is to be given, the attention must be on the work rather than on the worker. In order to keep criticism objective, the following techniques for reprimand are recommended: (1) Be sure you have all the facts. Be sure the cause of the trouble lies with the individual and not with poor equipment or poor working conditions. The supervisor must make certain that the delinquent knew that the rule had been broken or the error had been made and understands its seriousness. (2) Try to look beyond the reason for the reproof to the reason for the failure. People rarely fail because they choose to but more often because they do not understand what is required of them. If the mistake is from lack of information, the supervisor may consider himself at fault. Often, under stress of sudden emotion, a person impulsively does the wrong thing. In handling such cases the leader must be far sighted since when he fails to understand the cause of the error he often kills initiative in the individual and discourages other workers.

Offer reproof in private. The real function of a reprimand is preventive. Its purpose is to insure that a particular difficulty does not arise again and that the right working attitude and relationship of the individual to the group are fully restored. Some recommend a preface by a few words of appreciation of good things in the individual's record. The tone of the reproof should be positive. It takes courage to tell a worker what is wrong, but the ability to give constructive criticism in a way that does not cause resentment is one mark of an experienced and successful leader.

F. *Giving commendations.* Individuals unquestionably put forth more effort and do better work when they are commended at judicious intervals than when they are criticized. "Judicious approval" should be emphasized because indiscriminate insincere praise wins neither respect nor appreciation from the recipient. While a rebuke should be given in private, commendation often is most effective when given in public.

G. *Counseling and guidance.* The individual conference between the supervisor and staff member is one of the most effective tools in promoting growth and there is no substitute for it. The modern trend is to recognize that good personal adjustment of the staff is primarily the responsibility of the supervisor. A conference does not necessarily presuppose that matters of unpleasantness or dissatisfaction are to be discussed. It becomes a way for the supervisor to know each individual better and to evaluate his experiences and accomplishments. On the basis of this knowledge the supervisor is in a better position to encourage the staff member to achieve according to his potentialities and to correct any weaknesses. Counseling is a person-to-person relationship in which one who is presumably better informed, better adjusted and who has greater insight undertakes to help another. There will be varying degrees of success depending on the insight and understanding of the counselor.

The supervisor in conducting the interview should follow well established interviewing techniques. The conference should be arranged to allow for privacy and freedom from interruption. It is recommended that consideration be given prior to the interview as to the nature, content and approach best suited to the individual. The supervisor should cultivate an approachable and understanding attitude. He should attempt to create an atmosphere of informality and ease and encourage a freedom to talk. He should maintain an open mind and demonstrate objectivity by his manner. There must be assurance that all which is said will be held in strictest confidence.

If the interview is with a troubled or dissatisfied worker, the supervisor should attempt to establish rapport at the beginning with kindly questions or comments. The staff member is then allowed to direct the course of the interview freely without being probed with questions, censored or advised. The supervisor listens and tries to understand. The facts may be presented and interpretations made as necessary. Questions should be worded in such a way as to provoke thoughtful consideration of the problem and lead to a logical solution. Possible courses of action with probable outcomes may be presented by the supervisor. Often the staff member clarifies his own thinking just by talking. If he arrives at his own solution in this manner, he becomes more self-reliant. Very often the problem disappears as a result of the relief from emotional tension which the talk has made possible.

H. *Direction of professional performance.* Much of the direction by the supervisor can be accomplished by example. If the leader sets a pattern for a high level of performance and behavior, the staff naturally falls into the same pattern. The function of the supervisor is to guide and develop individuals and the leader achieves only as he creates situations where those he leads can achieve. He must determine the strengths and weaknesses of each staff member and attempt to bring out the best of which each is capable. Recognition of work by a question which shows interest or a word of commendation is in itself a spur to greater growth. While defective work, carelessness or negligence can not be tolerated the supervisor must be careful not to make an issue out of inconsequential deviations from the normal. There must be avoidance of nagging and over-attention to minute details. The wise supervisor expects that the worker will meet the high standards which have been set. In most cases where workers are expected to become increasingly useful, to make contributions and to take more responsibility, they will respond accordingly. Morale results not from giving people something but from making the proper demands on them so that they may win the psychological rewards of achievement. Good discipline demands the correct performance of duty.

I. Teaching. A good supervisor is also a good teacher and must face this as an important responsibility since the growth of his staff is inevitably bound up with the accomplishment of his mission. In a mature professional group such as found in physical and occupational therapy, the supervisor should be a part of the learning group. An in-service educational program, to be successful, requires the active participation of all in both its planning and execution. In the orientation of a new worker, the teaching ability of the supervisor and his manner of approach to him will have considerable influence on the worker's future attitude toward supervision, the department and the organization as a whole. Again, the supervisor's ability as a teacher is important in training understudies so that work will go on even though a staff member is absent. The supervisor must be unselfish in his willingness to train an understudy, realizing that any person who is indispensable to an organization is a liability to it. It is well recognized that every supervisor's performance must be evaluated just as rigorously on how well he develops understudies within his staff as on any other factor for which he is responsible. The emotionally secure supervisor does not see others as constant threats to himself. A true leader uses his teaching and supervisory skills to build personalities. The supervisor can tell whether his staff is attaining group maturity by the extent to which it is developing inner sources of motivations, a clear sense of direction, ability to improve its own procedure and a high degree of satisfaction from the work.

CONCLUSIONS

There has been an attempt to emphasize that the modern concept of supervision is one of democratic leadership. Democratic leadership requires study, practice and a willingness to give unselfishly far beyond the line of duty. As with any other endeavor which is important, it requires effort, persistence, patience, work and more work.

A democratic supervisor has the personnel point of view. He knows that to gain the highest level of performance his undertakings must be more person centered than task centered. He has respect for the dignity and worth of each individual and believes and operates on the policy that all people are important. Staff members are encouraged to participate in the planning, initiating and execution of department activities. The democratic supervisor recognizes that widespread

(*Continued on page* 309)

FACTORS INHIBITING PROGRESS OF CEREBRAL PALSIED CHILDREN

LESTER M. BROWER, M.A., O.T.R.

The occupational therapist's sphere in the treatment of cerebral palsy is manifold. One function is in the realm of self-help skills. In this area, it is frequently observed that cerebral palsied children, having the manual ability to accomplish self-help skills, remain dependent in performing them. Certain psychological manifestations of brain injury complicate independence. Although not prevalent to the same degree nor characteristic in all cerebral palsied, these factors are significant. Cruickshank and Bice[1] suggest two kinds of diagnosis be made for every brain-injured child; (1) medical, and (2) "psychological for the purpose of determining the presence and extent of the psychopathological component."[2]

Strauss and Lehtinen[8] organized a number of these entities into perceptual disturbances, thinking disorders and behavior disorders. Some of these factors and how they can be accounted for when teaching lacing will be considered.

Perceptual disturbances. Perception is that mental action which gives meaning to stimuli received from the sense organs. Learning self-help skills depends mainly upon perceptions received from visual and auditory sensations. The basis of many psychological abnormalities in brain damage may stem from perceptual difficulties. If the meaning received from stimuli is disconcerted, it logically follows that behavior dependent upon these perceptions will be disordered.

Perceiving wholes, the process of integrating parts of wholes received from sensory receptors, may be deranged. Meaningful responses in such cases are disorganized. For example, the child may point out lacing which skips an eyelet hole in one or more places, but is unable to recognize the shoe as being improperly laced.

The foreground-background syndrome is another peculiarity attributed to faulty perception. The child may see the eyelet (foreground) which the lacing goes through, but is unable to distinguish it from the leather to which the eyelets are attached (background). Thus, he "loses" the hole which the lace tip goes through. A forced responsiveness to the background is not uncommon among perceptually disturbed children.

Perseveration is another factor sometimes seen in cerebral palsy. This persistent repetition can occur singly (a single repetition of the preceding response); repetitively (repeating the preceding response a number of times, like a broken record); and in delayed response (repeating a preceding response after several other responses are given). Perseveration occurs after a successful accomplishment. Instead of performing a new process, the child continues to repeat the previous successful performance. Repetition of a previous incorrect response is also displayed. After doing a procedure incorrectly, and then being instructed how to do it properly, the child may continue to perform in the same incorrect manner. As frustration sometimes results from unsatisfactory performance due to motor disability, perseveration in the "mentally normal" brain-injured child may develop into similar discomfort. The child wants to perform properly, but perseverates. This disturbs him and may result in other behavior disorders or in further perseveration.

Perception like most processes of the organism follows developmental patterns. In brain damage, the maturing nervous system is disturbed. Disordered perception may be a consequence.

Thinking disorders. Disorganized thought displays itself in different ways. Images, concept formation, reasoning, abstractions, and the ability to hold essentials in mind are sometimes irregular in the brain-damaged. In cerebral palsy, impaired thinking may be described as vague, hypothetical, unusual or uncommon, accidental, far-fetched, peculiar, unessential, imaginary, stereotyped, bizarre or fantastic.

Dissembled thinking influences appropriate action. Referring to cerebral pathology, Goldstein[4] found the brain-damaged may not be able to: detach ego from the outerworld or from inner experiences (will lace shoes properly when dressing, but may fumble with the lacing in a meaningless manner if presented with the same task outside of the dressing situation); assume a mental set willfully and consciously (may be able to lace from start to finish, but if lacing is partly completed by someone else, may not be able to pick up in the middle and continue); account for acts to oneself or to others (can lace, but cannot describe how it was done); shift reflectively from one procedure to another (can lace braces, but after completing the process has difficulty lacing shoes); hold in mind simultaneously various aspects (can choose the correct hole, but by the time the right lace tip is selected and carried across, the proper hole is forgotten); plan ahead ideationally (can not sym-

bolically show how to lace by going through the motions as in pantomime, but can lace properly on a shoe).

Behavior disorders. Brain damage may cause fluctuations, change, and lack of orderliness in the total organization of mental activity which influence behavior. The excitable, uninhibited child who suddenly breaks into uncontrollable laughter or crying when attempting lacing may be experiencing such effects. These inappropriate responses or catastrophic reactions may be characteristic in brain injury. Erratic, automatized, uncoordinated, uncontrolled, socially unaccepted, distractable, aggressive, restless, fearful, hyperactive, emotional, and motorally disinhibited are terms used in describing behavior of brain injured children with cerebral palsy.

Behavior from the damaged organism shows itself in many ways. For instance, lack of motivation, behavior common to many youngsters, may have a different basis in cerebral palsy. The child may become concerned over his limitation of being unable to choose the proper lace tip when they are both on the same side. Perhaps he really knows the correct lace to select, but due to perseveration or some other factors associated with the brain lesion, he continues to make the wrong response. Strong feelings may arise over the lack of control in this situation. Trying the new or continuing to acquire unlearned processes may then cease because failure is distressing and interferes with that sought for order.

Lacing impediments. It is difficult to distinguish the causes of particular abnormal qualities which obstruct the lacing process. Determining the why of a particular lacing disorder as being due to perceptual difficulties or other consequences of brain injury, will in all probability lead to conclusions based on conjecture and supposition. It is probably more valid to state that the particular lacing disability prevents success, and may or may not be due to the cerebral palsy.

A few lacing difficulties encountered by some cerebral palsied children at the Iowa Hospital School for Severely Handicapped Children are presented. Holes are skipped as if never seen. The child will cross over incorrectly, or not at all. Lacing is continued only on one side, and with one lace. The correct lace is grasped only to be placed in the opposite hand and through a hole on the wrong side. After performing correctly, the child suddenly stops and claims that he doesn't know how to continue. Lace tips are confused. When both laces are on the same side, the youngster relates which lace tip to take and where it goes, but does not follow his or the therapist's directions. Inconsistency displays itself by proper lacing one time and many errors the following time. Distractability, short attention span and lack of motivation are evident. The child is ready to give up after lacing one or two holes. Interest decreases even when the process is being done correctly. Minute imperfections on the shoe, a buckle, or part of the brace in line of view fixes the attention from the task at hand. Prodding is needed. In turning the leather back so the holes are accessible, attention is drawn to the hole nearest the finger grasping or pushing the leather.

Helpful methods. Robinault[7] pointed out the merits of certain techniques used with pre-school perceptually disturbed children. She demonstrated that children could learn to play with toys effectively utilizing factors disturbed by perceptual difficulties. This is extremely significant since features needed for learning particular skills although impaired, can still be employed with some degree of success. In cerebral palsy, occupational therapy is, in part, the science of teaching skills despite the handicap rather than seeking to improve perception, thinking, behavior and other effects of brain damage.

Detailed instructions for teaching lacing can be found in references 3, 5 and 6. A few procedures found helpful in working through some lacing difficulties are presented.

Practice shoes, devices and games were useful when manipulation problems were present, but in teaching the lacing pattern little if any carry over was made from these apparatus to the shoe on the child's foot.

For those having motivation difficulties, attempts were made to stimulate interest. Stories were told with frequent pauses for one or more holes to be laced. Games were played in which empty holes called water glasses were filled by placing the lace tips through them. For crossing over, expressions as "cross the street," or "jump the puddle" were used. However, success was not always obtained by these measures. One little girl reacted to the phrase, "cross the street," by emphatically commenting, "That ain't no street."

In some cases color cues were useful. With a crayon one lace tip was colored blue and the other red. The respective holes were also colored blue and red. Children were instructed to lace by matching the colors. They were told to place the blue tip into the first empty blue hole on the opposite side, and the red tip into the first empty red hole on the other side. The table shows the average number of errors made by five cerebral palsied children learning lacing with this method of color cues against the average number of errors made by these children learning lacing in their usual manner without color cues.

Table

Average Number of Lacing Errors Made With and Without Color Cues.

Children	Errors With Color Cues	Errors Without Color Cues
A	1.66	2
B	3.33	5
C	9.33	8.66
D	2	5
E	.33	2

The averages, derived by the arithmetic mean, were computed from the number of errors made in three attempts utilizing color cues, and from the number of errors made in three attempts without color cues.

When holes were skipped, covering all eyelet holes but one was sometimes advantageous. Isolation behind screens proved valuable for cutting out unwanted stimuli.

In each case errors were carefully evaluated. Attempts were made to devise methods which worked around the difficulty. Techniques used for one child did not always work for another.

There is one other factor which should be considered. Perhaps it should be looked upon as an approach or point of view to therapy in cerebral palsy. In treating these children, occupational therapy finds itself engaged in the teaching profession. This is not a unique position for the occupational therapist, but in stressing self-help skills, teaching becomes a very intricate part of the treatment program. Patient-therapist association should readily lend itself to pupil-teacher relationship. We are not treating patients with skills, but rather teaching skills to children. "Teaching therapists" should place as much emphasis upon the processes of learning in relation to the child as they place upon the treatment program in relation to the patient.

SUMMARY

This paper has dealt with some psychological factors in cerebral palsy which may inhibit progress. Some lacing difficulties encountered have been mentioned, and a few methods used were discussed. It was pointed out that the dual role of therapist and teacher is assumed when dealing with self-help skills in cerebral palsy.

REFERENCES

1. Cruickshank, W.M., and Raus, G.M., editors, *Cerebral Palsy, Its Individual and Community Problems*; Chapter 4, "Personality Characteristics," Cruickshank, W.M., and Bice, H.V. Syracuse University Press, 1955, pp. 115-165.
2. Cruickshank and Raus, p. 156.
3. "Dressing Techniques for the Cerebral Palsied Child. Part II, Fastenings." *American Journal of Occupational Therapy*, 8:48-51, 69-70, no. 2, March-April, 1954.
4. Goldstein, K., and Scheerer, M., "Abstract and Concrete Behavior: An Experimental Study With Special Tests," *Psychological Monographs*, 53:1-10, no. 2, 1941.
5. McConahey, F.H., *Dressing Helps for Parents of Children With the Athetoid Type of Cerebral Palsy*, mimeographed paper, 1952.
6. Robinault, I.P., "Have You Tried," *American Journal of Occupational Therapy*, 6:237, no. 5, September-October, 1952.
7. Robinault, I.P., "Perception Technics for the Pre-School Cerebral Palsied," *American Journal of Occupational Therapy*, 8:3-5, 7, no. 1, January-February, 1954.
8. Strauss, A.A., and Lehtinen, L.E., *Psychopathology and Education of the Brain-Injured Child*, Grune and Stratton, New York, 1947.

Mid-year meeting of the Board of Management of the American Occupational Therapy Association is scheduled for April 5, 6, 7 at the Hotel Coronado, St. Louis, Missouri.

Baylor University College of Medicine, Southwestern Poliomyelitis Respiratory Center, and the Jefferson Davis Hospital, in cooperation with the National Foundation for Infantile Paralysis, Inc., announce their fourth postgraduate course for physicians, occupational and physical therapists, nurses and medical social service workers to be held February 25 through March 1, 1957.

The course on "Practical Management of Poliomyelitis and Principles of Rehabilitation" will cover complete care of poliomyelitis with emphasis on the severely involved patient, the effective coordination of services and the principles of rehabilitation.

The tuition fee will be $25.00. For further details write to Dr. William A. Spencer, Medical Director, Southwestern Poliomyelitis Respiratory Center, Education Office, 1300 Kenwood Lane, Houston, Texas.

In Memoriam

Miss Alma J. Ball
Hermosa Beach, California
Deceased September 11, 1956

Miss JoAnn H. Cohen
Chula Vista, California
Deceased September 11, 1956

Mrs. Frances H. Ehrhart
Trumansburg, New York
Deceased October 6, 1956

Miss Margaret N. Liebert
Bethlehem, Pennsylvania
Deceased September 21, 1956

Miss Ruth Marion Miller
Detroit, Michigan
Deceased July 27, 1956

Mrs. Martha W. Redden
Brooklyn, New York
Deceased September 28, 1956

MOTIVATION AND PERSONALITY DEVELOPMENT

HELEN PARRISH MILLER*

Why are some people aggressive while others are submissive? Why are some people obstinate, overbearing or cruel, when other people are obedient, mild and modest? "Psychologists have long been fascinated by the search for the causes of human behavior."[7] And there "has probably been more speculation on motivation than any other aspect of personality."[7] Since we "cannot think, feel, will or act without the perception of some goal,"[1] "the study of motivation must be in part the study of the ultimate human behavior; the schema concept developed to han-

Many theories of motivation have been conceived. For example: trait psychology developed to explain recurrent responses and consistencies in behavior; the scheme concept developed to handle the problem of what the person knew; and the motive concept developed to answer the question of why.[7] It would be difficult to discuss all of the vast number of motivational theories and their relation to personality development; but we will try to discuss briefly some of the major viewpoints.

FREUD'S CONCEPT

Freud was primarily concerned with the dynamics of human motives and with the development of personality. His studies of motivation in persons who were mentally disturbed led him to develop certain theories concerning the drives and emotional life of normal people.[3]

Freud felt all behavior was motivated, no matter how trivial the act may appear. In fact "he made a specialty of analyzing the causes of odd bits of behavior-superstitions, faulty actions, slips of the tongue, jokes, dreams, etc."[7] He also felt motives were persistent and he developed the theoretical position that motivation consists of continuous under-lying tensions which will continue to express themselves no matter how they are blocked or disowned by the person. He conceived of it as a continuously driving factor which persisted from birth to death despite attempts of the environment to mold and deflect it.[7] Many times motives are unconscious and unknown to the subject. Freud says, certain "inadequacies of our psychic functions . . . and certain performances which are apparently unintentional prove to be well motivated when subjected to psychoanalytic investigation, and are determined through the consciousness of unknown motives."[8] Likewise he thought that motivation was essentially tensional in character and life so full of aggression and frustration that the major task of man seemed to be to try to find ways to alleviate pain, avoid anxiety and reduce tension, the reduction of this tension being rewarding or gratifying. He wrote, "the bitter truth behind all this—one so eagerly denied—is that men are not gentle, friendly creatures wishing for love, who simply defend themselves if they are attacked, but that a powerful measure of desire for aggression has to be reckoned as part of their instinctual endowment. The result is that their neighbor is to them not only a possible helper or sexual object, but also a temptation to them to gratify their aggressiveness on him, to exploit his capacity for work without recompense, to use him sexually without his consent, to seize his possessions, to humiliate him, to cause him pain, to torture and to kill him."[2]

Apparently in the beginning Freud explained all striving in terms of "two powerful instincts; the ego instinct and the sex instinct. The first is identified with self-preservation and is active in hunger, fear, self-assertion. The second includes not only the urge toward reproduction and normal sexual desire, but almost any kind of pleasure seeking."[3] By "hunger," Freud meant not only desire for food but the ego instinct in general, the aggressive striving for mastery. Passion he takes to include all that pertains to sex in a wide sense and together hunger and sex are thought of as shaping the course of personality development.[3] "Later on Freud reduced this dualism to a monism in which the libido remained the primary instinct and the conflict arose between the portions of the libido which remained attached to the self and the portions which were directed toward others . . . Finally he developed a second dualism, this time between the libido or life instinct and the death instinct."[7] In all of these changes the motivation of the libido remained and Freud thought it accounted for almost all striving.

Freud thought of motivation as being basically instinctual in nature with the libido developing in stages in much the same way as the fetus develops. He also thought that "all psychological or higher motives tend to seek gratification in a manner which is patterned after the way in which the underlying biological drive was originally satisfied. And finally that "the early manifestations of the libido are of greatest importance in character formation. Later motivational developments are derivative and for the most part substitutions for 'aim-inhibited strivings.' This is, when the libido cannot reach its

*Student at Richmond Professional Institute, College of William and Mary, Richmond, Virginia.

original aims because of the frustrations of socialization or for other reasons, it is forced to adopt substitute aims."[7]

CONCEPTS OF LEWIN AND ALLPORT

In general Freud's viewpoint has been very influential, but it has not been accepted by everyone, notably Lewin and Allport. Lewin like Allport was structurally rather than historically oriented in his theory of motivation. "His contribution has consisted largely of 'situational' or field analysis of motivated behavior."[7] The field is the environment which has forces (motives) "acting upon the person from within or without."[3]

Allport objected to the labeling of adult motivation to infantile biological ones, and he developed the concept of "functional autonomy." He believes that the biological drives might serve to account for the behavior of infants and might serve as the original basis for the development of psychogenic motives; but once they are formed, the psychogenic motives have no connection, whatsoever, with the original biological drives. "In his theory he does not go much beyond providing evidence for the fact that motives do appear to function autonomously."[7] Likewise, he does not suggest what motives should be used to conceptualize the human adult personality, but rather "Allport insists that generality prevails in the organization of the personality."[5]

HORNEY'S CONCEPT

Horney likewise has objected to Freud's "instinctivistic and genetic psychology."[4] "She and others in her group have emphasized the importance of cultural environment, or sociological factors in motivational development. In other words she believes that motives are genuine learned products of experience and do not simply reflect always the inhibited striving of a primary biological instinct."[7] She writes, "when character trends are no longer explained as the ultimate outcome of instinctual drives, modified only by environment, the entire emphasis falls on the life conditions molding the character and we have to search anew for the environmental factors responsible."[4] Therefore, a "prevailingly sociological orientation then takes the place of a prevailing anatomical-physiological one."[4]

She starts with the fact that a child is small and relatively powerless and feels the need for security and safety in a potentially dangerous world. Because of these the child develops what she calls "the concept of basic anxiety . . . It contends that the environment is dreaded as a whole because it is felt to be unreliable, mendacious, unappreciative, unfair, unjust, begrudging and merciless. According to this concept the child not only fears punishment or desertion because of forbidden drives, but he feels the environment as a menace to his entire development and to his most legitimate wishes and strivings. He feels in danger of his individuality being obliterated, his freedom taken away, his happiness prevented."[4] "In the face of these circumstances the child resorts to building up certain defensive attitudes . . . which enable him to cope with the world and at the same time allow him certain possibilities of gratification. Whatever attitudes he develops depend entirely on the combination of factors present in the whole situation: whether his prevailing striving will be for assuming control, for being submissive, for being unobtrusive, or for walling himself in and drawing a magic circle around himself, preventing intrusion into his privacy, depends on which ways are in reality closed to him and which are accessible."[4]

ADLER'S CONCEPT

Adler differs from Horney in that he says, "the psyche has as its objective the goal of superiority."[1] He also started with the fact that the child begins life smaller and more helpless than the adults in his society and realizes that he is not able to get what he wants as well as the adults. "This arouses in him a strong need to compensate for his observed inferiority and all striving is directly or indirectly aimed at overcoming the initial, biologically-given helplessness."[7] "Whether a person desires to be an artist, the first in his profession, or a tyrant in his home, to hold converse with God or humiliate other people; whether he regards his sufferings as the most important thing in the world to which everyone must show obeisance, whether he is chasing after unattainable ideals or old deities, over-stepping all limits, and norms, at every part of his way he is guided and spurred on by his longing for superiority."[1] "In order to gain control over an object or over a person, he is capable of proceeding along a straight line, bravely, proudly, overbearing, obstinate, cruel; or he may on the other hand prefer, forced by experience, to resort to by-paths and circuitous routes, to gain his victory by obedience, submission, mildness and modesty."[1] Thus Adler feels this goal of superiority has become the main drive in our lives.

MASLOW'S CONCEPT

Maslow has integrated a number of approaches to motivation into an overall scheme which he calls the hierarchy of motives. "He argues that the physiological tensions, for instance, are prepotent until they are satisfied, at which point other motives take over."[7] Following is his list of needs in the order of basic importance to the organism:

(*Continued on page* 310)

THE EFFECT OF THE PROFESSIONAL ACTIVITY OF OCCUPATIONAL THERAPISTS ON THE BEHAVIOR OF MENTAL PATIENTS*

EILEEN DIXEY, O.T.R.
G. M. HASLERUD, PH.D., and N. C. BROWN

In addition to its usefulness in the hospital therapeutic process, the occupational therapy clinic can also be a behavioral laboratory. Dr. R. W. Hyde developed a technique for such use of occupational therapy in a study of pre- and post-lobotomy changes in behavior[2] and standardized it[3] for further research. From the latter study Dr. Hyde finds evidence for thinking that in conventional occupational therapy "the patients are usually over-controlled, over-protected, and over-directed," and that by providing for variations in control one can detect spontaneity and creativity. The experimental clinic hour would be divided into a series of ten-minute periods. In the first the occupational therapist is not even in the room; the second the therapist is available; the third suggestions are made, e.g., "Why not working?"; the fourth those not yet working are commanded to do so; and in the fifth all are asked to clean up. Dr. Hyde mentions how difficult it was to train occupational therapists to hold to the above schedule.

The Hyde technique ought to make us ask: What do occupational therapists actually do in the regular occupational therapy clinic? What difference does it make in the patients' effective productivity whether the occupational therapist is thus professionally active or merely present? Since Dr. Hyde reported, " . . . an unexpectedly large number of patients engaged in tasks during the first period (the ten-minutes when no occupational therapist was present) without personal direction,"[3] a serious question is raised about the very role of the occupational therapist. It is apparent that a need exists to test the following three hypotheses:

1. Patients will show little or no effective production in the occupational therapy clinic without initial stimulation by the therapist.

2. Patients will show, compared to a period of no direction, an increase in productivity when the occupational therapist is professionally active.

3. Patients will show a decline in productivity when effective occupational therapeutic direction is withdrawn, but the decline will be moderate and many patients will maintain some part of the previous gains in activity.

Similar hypotheses need testing regarding socialization in the occupational therapy clinic. If the third hypothesis can be supported, it may offer a suggestion on how optimally to use occupational therapists who are in short supply.

PROCEDURE

A. *Subjects.* One male and one female occupational therapist with approximately the same training and experience were selected to provide a greater variety of therapists and to test whether the sex of the therapist would significantly influence the patients' activity.

Forty-eight male chronic patients, median age 46 (range 20 to 80) and median duration of hospitalization 10 years (range 1 to 39), were selected by two doctors to be representative of the men in their building who could possibly be included in the study, and who had not attended the occupational therapy clinic in the past year. Twelve of the patients were being treated with reserpine or chlorpromazine. This was not made known to the observer until the end of the experiment. The patients were organized into groups of four for the experiment, each of the four patients from a different ward to minimize previous social contact.

B. *Apparatus.* Nine simple, individual tasks were arranged in standard fashion in the regular occupational therapy clinic for each test of a group of four patients. With the frequencies of use following each item, these tasks were:

An assortment of colored jersey loopers to be sorted into separate containers from one large one. (19)

Partially painted chair with can of paint and brush. (25)

Partially sanded piece of furniture and sandpaper. (13)

A ball of modeling clay and some partially finished pieces of modeling. (9)

---

*From the Department of Psychiatric Research, New Hampshire State Hospital, Concord, New Hampshire.

We wish to thank Dr. Earl K. Holt, superintendent, for administrative arrangements and encouragement for the project; Dr. G. Donald Niswander, director of psychiatric research and education, and Dr. Slim Lind, psychiatrist, for selecting the subjects; Mr. Leslie Baker, O.T.R., and Mrs. Martha Wickham, O.T. Reg., the occupational therapists; and the members of the research council of the hospital who made many helpful suggestions. Mr. Brown acted as observer to collect the data as part of a Master's thesis written under the supervision of Dr. G. M. Haslerud, department of psychology, University of New Hampshire. Miss Dixey is the director of the occupational therapy department of the New Hampshire State Hospital.

An easel with crayons for drawing. (9)

A pair of scissors and drawn, uncut tags to cut out. (19)

A skein of yarn partially wound into a ball. (3)

A drill and partially completed holes in a cribbage board. (20)

Sewing equipment and buttons to be sewed on shirts needing some buttons. (10)

It is obvious that the tasks differed in their attractiveness for the patients.

C. *Technique.* The twelve groups of patients on four successive days were exposed to the occupational therapy clinic for 15-minute periods each day. Each therapist conducted the sessions with six groups under two distinct conditions—active and passive. In the active session the therapist performed his duties in a normal fashion. During the passive session the therapist remained seated at his desk, doing work of his own and appearing to be oblivious to what the patients were doing. He was instructed, however, to be permissive; if asked permission to do something he was to respond, e.g., "Yes, if you want to."

Table I shows how the 12 groups were scheduled to provide a balance of active and passive sessions in first and other positions and a balance of therapists so that each patient would have each therapist in each of the experimental conditions. This is to be read for the first three groups in the following manner: The first day the male therapist acted in his usual professional way; the second day the female therapist was passive; the third day the male therapist was passive; and the fourth day the female therapist was professionally active.

A time-sampling method[4] was used to gather the ratings of behavior of both the patients and therapists. The observer was seated inconspicuously in the corner of the room but in such a position that he had a full view of the room. A 15-second observation was made of every person nine times during each 15-minute session. Thus the observer would make a 15-second observation of one person, record his ratings and notes during the next 5-seconds, and then observe another. The patients wore colored name tags, and the observer identified them by the color rather than the name.

Prior to entering the occupational therapy room all patients were told exactly the same thing. They were instructed only that the doctor expected them to go to occupational therapy. No information was given concerning the nature of the experiment or what they were to do in the occupational therapy clinic. No smoking was allowed during the sessions, as it would probably be a distraction in a 15-minute period. However, cigarettes were given to patients desiring them to signal the conclusion of the session without the regular clean up period.

D. *Ratings.* The occupational therapists were checked for any of the kinds of activity listed in Table II during each of the nine observation periods per session. More than one kind of activity might be checked as occurring within a 15-second observation.

The patients were rated on scales of activity and socialization, and note was also taken of the task in which engaged. For activity, the lettered scale involved four steps, not necessarily equal in size:

R. no directed activity.

S. patient looks at a task but does not touch it or make other contact with it

T. close observation and attempts to perform the task.

U. successful performance of task.

For socialization the scale had five categories:

1. Complete withdrawal, no communication of any kind
2. No withdrawal but no communication of any kind
3. Direct verbal communication with the therapist
4. Spectator activity, concern in what others are doing
5. Direct verbal communication with other patients in the group

E. Controls: In this experiment, each patient and each therapist acted as his own control as shown in Table I.

TABLE I

Schedule of Conditions According to Days and Groups (*A* for therapist when active professionally, *P* for therapist when passive; 1 for male therapist, 2 for female therapist)

Groups	1st day	2nd Day	3rd Day	4th Day
1-3	A1	P2	P1	A2
4-6	A2	P1	P2	A1
7-9	P1	A2	A1	P2
10-12	P2	A1	A2	P1

A reliability check was made to determine whether the ratings of the observer were of such kind and were taken under such conditions that one could have confidence in them. During the passive sessions, the therapists made independent ratings of the patients at the same time as the observer to determine the degree of variation in rating the same patient at the same observation period.

RESULTS

The reliability of the rating in the passive situation was very high. For task activity there was perfect agreement in 94% of the ratings and an additional 5% where the rating differed by only one step. For socialization the agreement between the two observers was perfect in over 99% of the rating periods. This concordance gives reason to think the observer's ratings in the active session were also highly reliable on both patients and therapists.

Table II lists the activities of the therapist arranged according to frequency. One can easily see that the positive social factors of interested obser-

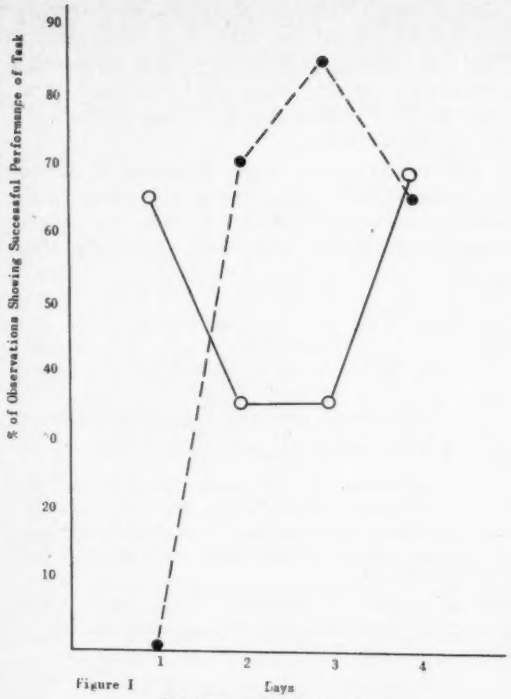


Figure I

Performance of patients related to changes in activity of the occupational therapist. (solid line for APPA, dotted line for PAAP)

vation, encouragement, and conversation was more frequently engaged in than the technical skills of demonstrating or describing a task. It is significant that at no time during the four days was coercion recorded. Although there was a slight tendency for the female therapist to give more suggestions and to participate more in the tasks, Table II supports the conclusion that the work of both therapists was similar in method.

Turning now to the results on the ratings of patients, we can see in Figure I support for the three hypotheses which were posed. Only the ratings for effective productivity (U) are graphed because the complements R and U account for approximately 95% of the ratings. One will notice that no patients were active when a passive session introduced the individual to the occupational therapy clinic. In contrast, a dramatic output of productive activity occurred when the A or active role by the therapist was the one met by the patient. Finally a P session after an A resulted in a drop in productivity although, as stated in the third hypothesis, it was moderate and showed some persistence of the previous active stimulation.

If we consider the 48 individuals rather than their total of 1728 observations shown in Figure I, we get the percentages shown in Table III.

Table III indicates that very few of the patients perform in a direction different from the group as a whole. In other words, the results are not a statistical artifact made by a few atypical individuals.

TABLE II

Behavior of the Occupational Therapists in Percentage of 108 Active Period Observations (9 for each of 12 groups)

	Male Therapist	*Female Therapist*
Observation of patients performing task	62%	57%
Encouragement	47%	44%
Conversation not related to work at hand	40%	44%
Suggestion of various ways of performing task	32%	41%
Description of task to explain what is involved in its performance	32%	26%
Participation in the task demonstrating how it is done	20%	29%
Coercion of any type	0%	0%
Activity unrelated to patient	0%	0%

The twelve patients under reserpine and chlorpromazine treatment received ratings similar to the 36 others. Because they were scattered at random in the 12 groups, and no design was employed to test drug versus non-drug patients, the present experiment allows only the observation that disturbed patients receiving ataraxics were able to participate adequately.

The ratings of socialization indicate that practically none occurred between patients (rating 5) but that in the initial active session, about 20% of the time samplings showed conversations with the therapist. As they got into the task, this percentage declined about half. Of course the patients were from different wards and thus comparative strangers and also the tasks were simple and individual.

DISCUSSION

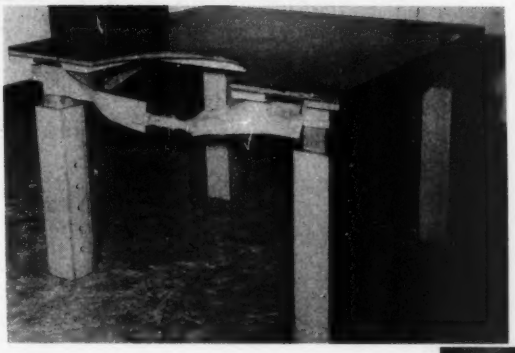
These time sampling observations dispose of any notion that the occupational therapist is primarily a demonstrator of skills in various crafts. Instead, a much larger proportion of his time is spent establishing rapport and good personal relations with the patients through interested observation, encouragement and conversation.

No differences that could be called significant were found between the ratings of the male and female therapists, although it had been presupposed that the male patients might be more active in the presence of the latter. The sample of the sexes is, of course, too small for generalization, but it seems that social technique may be more important than sex differences.

Our results, within the limitation of a four-day schedule, run counter to the finding by Dr. Hyde of "an unexpectedly large number of patients engaged in tasks during the first period without personnel direction."[3] In our group of 48 chron-

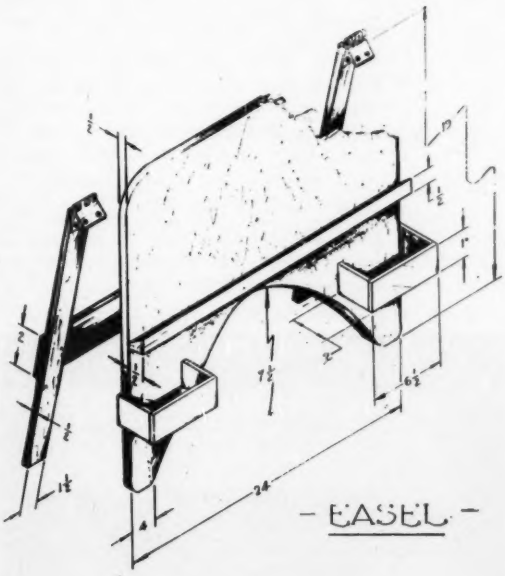
(*Continued on page 303*)

Picture Page



ADJUSTABLE TABLE

The large picture shows an adjustable standing table for adults with area removed so patient may get elbow support when either standing or sitting. Leather strap may be buckled when patient is standing to give support. Table may be raised by lifting top and inserting dowels in legs. Minimum height 32", Maximum height 48". The table top may be raised at various angles as shown in the smaller picture. This is particularly convenient for patients in neck brace or hyper-extension of the back.[1]



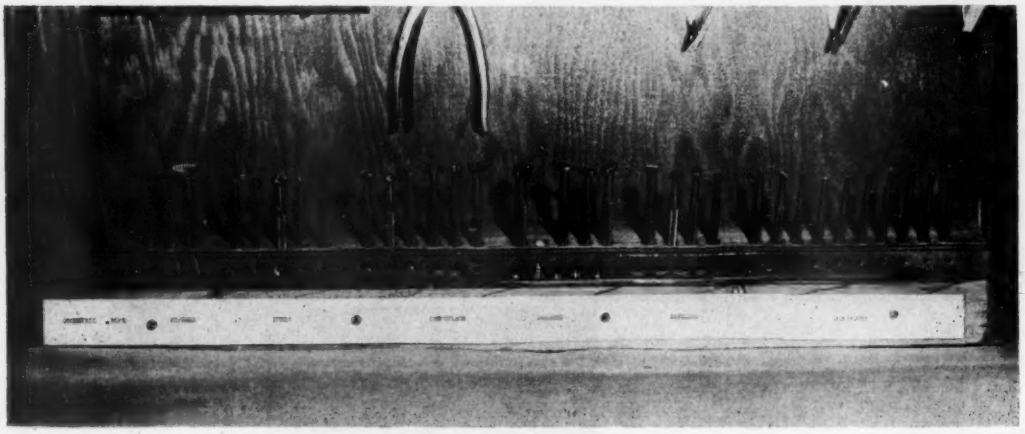
EASEL

This easel, as shown in the line drawing and the picture below, was designed primarily for use on the pediatric ward. It has a ledge to hold 2-oz. jars of paint, crayons, pencils, etc. The angle of position is adjustable.[2]

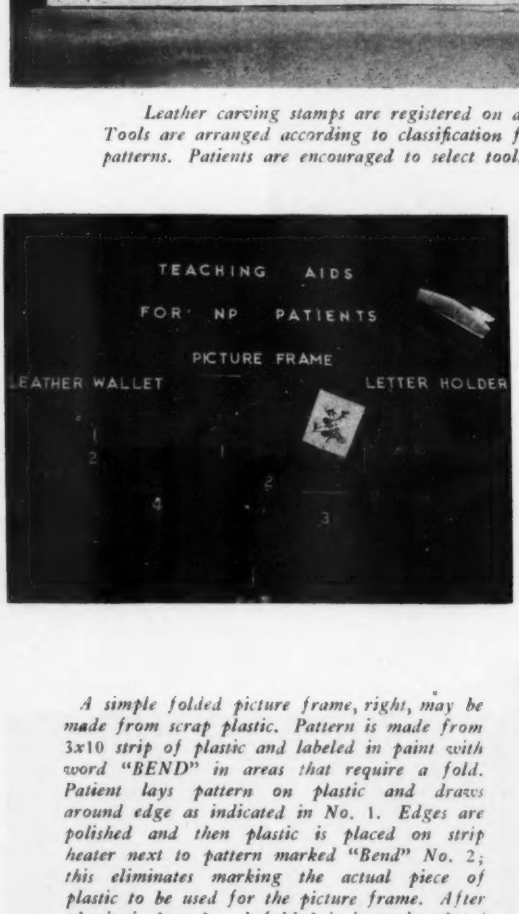
1. Pictures from Fitzsimmons Army Hospital, Denver, Colorado.
2. Pictures from Walter Reed Army Hospital, Washington, D. C.

TEACHING AIDS FOR NEUROPSYCHIATRIC PATIENTS*

An opportunity should be provided for neuropsychiatric patients to permit them to display increasing initiative and independence in their participation in occupational therapy activities. Simple visual aids and labeled patterns can do much to help establish the desired atmosphere.



Leather carving stamps are registered on a strip of leather and mounted below the tools. Tools are arranged according to classification for easy comparison with those suggested in the patterns. Patients are encouraged to select tools independently with minimal supervision.



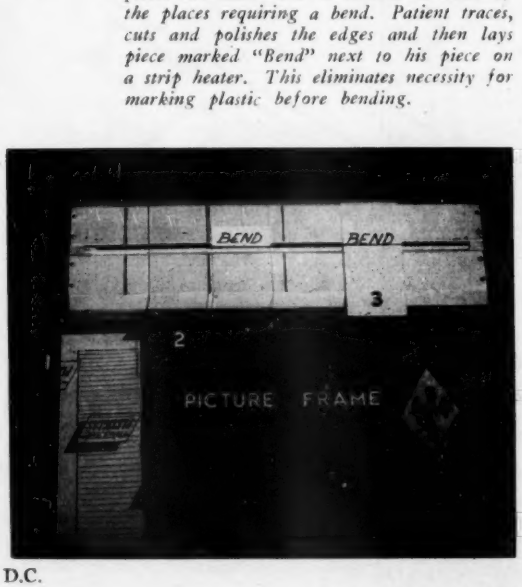
Labeled patterns as pictured on the left provide opportunity for patients to participate in activity with more independence.

a. *Leather wallet—four pattern pieces are cut from plastic to aid patient in tracing. Pieces No. 1 and No. 2 may be used on either side; pieces No. 3 and No. 4 however must be placed on leather in a specific way so they are labeled "This side up."*

b. *Plastic picture frame—pattern is labeled No. 2 and is used for tracing. Illustration shows steps in making a folded picture frame.*

c. *Plastice letter holders—two plastic pattern pieces are used—one is labeled at each of the places requiring a bend. Patient traces, cuts and polishes the edges and then lays piece marked "Bend" next to his piece on a strip heater. This eliminates necessity for marking plastic before bending.*

A simple folded picture frame, right, may be made from scrap plastic. Pattern is made from 3x10 strip of plastic and labeled in paint with word "BEND" in areas that require a fold. Patient lays pattern on plastic and draws around edge as indicated in No. 1. Edges are polished and then plastic is placed on strip heater next to pattern marked "Bend" No. 2; this eliminates marking the actual piece of plastic to be used for the picture frame. After plastic is heated and folded it is again placed on the heater next to second pattern piece No. 3 and is again bent to make a stand for the frame. Second pattern piece No. 3 may be omitted if end of fold is placed just anterior to the heating coil in the strip heater.



*Pictures from Walter Reed Army Hospital, Washington, D.C.

Activity . . .

(*Continued from page 300*)

TABLE III

Percentage of Individuals Rated as Successfully Performing a Task (U) During a Majority of Their Nine Observation Periods of Each Day (Refer to Table I for explanation of A and P)

Day	APPA (24 patients)	PAAP (24 patients)
1	80%	0%
2	46%	83%
3	42%	96%
4	71%	67%

ic patients who had not been to the occupational therapy clinic within a year, the establishment of a work atmosphere by the occupational therapist was necessary before any productivity occurred in the *PAAP* groups. The standing around during the initial passive session may have reflected hospital custom to await direction and permission. In the Hyde laboratory instruction cards were attached to the tasks[3]; also Dr. Hyde does not indicate whether his patients were as naive concerning the occupational therapy clinic as those in this study. Our results indicate that considerable productive activity may continue, though at a lower rate than in the preceding active session, into one or more passive sessions. If Dr. Hyde's patients in the experiment were tested after previous occupational therapy clinic experience, then there is no conflict between his statement quoted and ours that no productivity occurred until the occupational therapist became professionally busy. All groups responded strongly to the active role of the therapist and showed some decline when the passive role was again assumed. Thus all three hypotheses were supported.

The moderate downward shift during *P* after *A* makes one interested to know what would be the cumulative effect of *AAAA* or *PPPP*. Also the moderateness of the drop makes plausible the increased use of occupational therapy aides.[1] If the social work-atmosphere were kept up by another warm personality, interested in the patients, even though less trained in occupational therapy, the decline might be minimal when the professional occupational therapist left a group at times to initiate other groups.

BIBLIOGRAPHY

1. Frye, George D. and Harold Shalik, "Selecting and Utilizing the Occupational Therapy Aide." *The American Journal of Occupational Therapy*, 9: 190-192, 203, 1955.
2. Hyde, Robert W. and Wood, Anne C., "Occupational Therapy for Lobotomy Patients." *Occupational Therapy & Rehabilitation*, 28: 109-124, 1948.
3. Hyde, Robert W. and Barbara Scott, "The Occupational Therapy Research Laboratory." *Occupational Therapy & Rehabilitation*, 30: 133-146, 1951.
4. Olson, Willard C. *The Measurement of Nervous Habits in Normal Children*. Minneapolis: University of Minnesota Press, 1929.

EDITORIAL

CONSTRUCTIVE CRITICISM

This issue completes the first ten years of the American Journal of Occupational Therapy. The Journal has, in these years, become an integral part of the American Occupational Therapy Association. The advent of the Journal was carefully planned and the vision of the Board of Management during the early stages was progressive and sound. There has been little need for any marked changes in the policies or plans for the Journal over the past decade.

However in reviewing the ten volumes, subtle changes are apparent. Discounting the changes in size and the improved typography which are mechanical details, there has been an increase in the range of article material, more diversification of interests and most important, a growing criticism of our endeavors.

These changes are important. Though subtle, they indicate the growth of occupational therapy as a profession. And most heartening of all is the increase in the critical analysis of our work. We know we are not perfect but we also know from criticism that we are effective else we would be ignored. It is encouraging that articles analyzing our contributions but outlining ways to increase our status are on the increase. It supports the conclusion that occupational therapy is being recognized with growing respect and consideration. The profession is evidently acknowledged as sufficiently established to no longer need verbal "pats on the back." Our contribution in the medical field is now accepted and the growing criticism is proffered as an aid to help us develop the full potentiality within our province.

It is interesting to note that the critical articles have come mostly from physicians. They must see a perceptibly improved future for us that will be much more effective than our present status. They are attempting to goad us constructively into assuming our full responsibility and potentiality.

The fact that these professional people have taken the time and interest to analyze our weaknesses and define our future responsibilities is heartening. It also places a responsibility on us not to fail this trust that they feel we are capable of assuming.

Therefore while reviewing our past ten years and looking forward to our promising future, let us take the time to appreciate and give thanks to the many friends who, through their criticisms and analyses, have enabled us to keep our goals clearly outlined, namely, the physicians whom we have been endeavoring to serve but who in reality have served us through their encouragement, criticisms and valuable advice.

NEW OFFICES OF AOTA

A visitor waits in the reception area as Frances Quinn, receptionist and registration secretary, calls a staff member to announce her arrival. Mrs. Gertrude Abrams, membership secretary, is behind her while Lilian Jaffe, secretary to the executive director, is at the files in the inner office area.

A professional-secretarial staff meeting in the handsome conference room and library of the new AOTA headquarters. Marjorie Fish, executive director, is at the head of the table with her assistant, Mrs. Frances Shuff, at her right; Rheta Glueck, director of public information, is at the far right. Others, left to right around the table are: Margaret Pressly, secretary to the director of public information; Suzanne Hecht, secretary to the education office; Mrs. Libby Mevorach, former staff member back for the billing season; Frank Dodds, mail and stockroom clerk; Lilian Jaffe, secretary to the executive director; Mrs. Gertrude Abrams, membership secretary; Mrs. Lilly Meyer, bookkeeper; Mrs. Mary Friedman, former staff member back for the billing season; Mrs. Ann Walitsky, secretary to the general and education offices, and Frances Quinn, receptionist and registration secretary. Staff members missing from the picture are Mary Frances Heermans, educational secretary, and Dr. Hyman Brandt, educational research consultant.

A professional staff conference in the executive director's office. Talking things over with Miss Fish are (left to right) Mrs. Frances Shuff, assistant to the director, and Rheta Glueck, director of public information. Mary Frances Heermans, educational secretary, was on a field trip when the picture was taken.

NATIONALLY SPEAKING

NEW OFFICERS

New officers of the American Occupational Therapy Association elected for the coming year are:

2nd Vice-President: Florence Stattel, O.T.R., re-elected.

Board of Management members:

Re-elected

Marie Louise Franciscus, O.T.R.
Caroline Thompson, O.T.R.

Elected

Elizabeth Messick, O.T.R.
Mary Reilly, O.T.R.
Myra McDaniel, O.T.R.

Wilma West, O.T.R., who was treasurer-elect during the past year, took office as treasurer at the last meeting of the Board of Management held during the 1957 conference in Minneapolis in October.

A complete list of officers is listed on the masthead, page II.

The newly elected officers of the House of Delegates are:

Speaker: Margaret K. Mathiott, O.T.R.
Vice-Speaker: Marian Wright, O.T.R.
Secretary: Dorothy Deer, O.T.R.
Representatives to the Board of Management:
Margery Peple, O.T.R.
Marion Crampton, O.T.R.

HONORS

At the annual conference held in Minneapolis, Minnesota, October 2-4, awards of merit were presented to Clare Spackman, O.T.R., and Dorothy Rouse, O.T.R. Miss Spackman is retiring as treasurer of AOTA after serving for nine years during which the solvency of AOTA has become assured.

Miss Rouse has retired as chief occupational therapist of the department of medicine and surgery of the Veterans Administration.

The contributions Miss Spackman and Miss Rouse have made to the American Occupational Therapy Association are of inestimable value and the tribute to them is richly deserved.

The 1956 Regional Institute

I wish it were possible to capture in words the enthusiasm, excitement and intense interest as they were manifested on the faces and in the voices of the participants of the four regional institutes co-sponsored by the American Occupational Therapy Association and the Office of Vocational Rehabilitation, U.S. Department of Health, Education, and Welfare. These emotions were indicative of the stimulation engendered by the various speakers and further charged by the powerful force of group dynamics.

The regional institutes were the direct result of a recommendation made at the institute held in New York in June, 1955, under the auspices of the American Occupational Therapy Association and the Office of Vocational Rehabilitation. The title was "A Reassessment of Professional Education and Practice in Occupational Therapy as Related to Rehabilitation."[1] The participating therapists considered their experience so valuable that they recommended additional institutes be planned on a regional basis to discuss the more valid points arising from the 1955 institute. In keeping with this, a proposal was written and forwarded to the Office of Vocational Rehabilitation requesting financial assistance in developing four institutes on a regional basis: east coast, mid-west, upper mid-west, and west coast. In this manner it was anticipated that a large number of practicing therapists in the student affiliation program could take part. The request was granted and we are again indebted to the Office of Vocational Rehabilitation for the oportunities inherent in such a program.

The institutes were held as follows:

June 5-8, Denver Colo.—*Group Dynamics and the Team Approach in Rehabilitation.*

June 12-15, Richmond, Va.—*Prevocational Techniques and Media.*

Aug. 6-9, Madison, Wis.—*Techniques of Instruction and Administration.*

Sept. 12-15, Los Angeles, Calif.—*The General Approach in Occupational Therapy.*

Colorado Woman's College, Richmond Professional Institute, the University of Wisconsin and the University of Southern California respectively assisted in the mechanics of the institutes by making available housing facilities, meeting rooms and many other services necessary for group meetings. We owe much of the success of the sessions to the able assistance offered by these institutions of higher learning.

The papers from each institute are being summarized. They will be published together in one volume in the near future. The recommendations will, of course, be included.

To date, the recommendations have been only roughly evaluated.[2] All have merit and show an understanding of the problems that confront us

1. American Journal of Occupational Therapy, Vol. IX, No. 4, July-Aug., 1955, p. 166.

2. A committee has been appointed by the council on education to review this material carefully and indicate methods of implementation when it reports at the mid-year meeting.

on the various levels of occupational therapy. With the implementation of those which are selected as guide lines for future development, occupational therapy will contribute more to the present day concept of total patient rehabilitation.

The objectives and methodology for the institutes were selected to ascertain specific and general recommendations on the basis of a reassessment of our present day education and practice. This was accomplished and concurrently other extremely valuable effects were realized. Most of these can be summarized by listing the strengths of group action structured around a mutual interest, having one idea lead to another, experiencing the cohesiveness of a group, and discovering that your ideas and problems are shared by others. Therefore, the opportunity of becoming a good group participant was one of the most important intangible values of the institutes.

Martha E. Matthews, O.T.R.
Coordinator
OVR Regional Institutes

Report on DACOWITS

The Defense Advisory Committee on Women in the Services was constituted in 1951 for the purpose of providing a consultant and interpretative group of civilian women to work with the Department of Defense on matters pertaining to women in the services.

Until just prior to World War II the only women in the services on a reasonably permanent basis were Army and Navy nurses. The three groups which now constitute the Medical Specialist Corps, namely, dietitians, occupational therapists and physical therapists served in a civilian capacity.

At the beginning of the war, legislation was enacted for the commissioning of dietitians and physical therapists in the Army Reserve while occupational therapists remained civilians.

In 1948 when the Women's Armed Services Integration Act was passed and women became a permanent and integral part of the military services it was evident that public interpretation on careers for women in the services was necessary. The Department of Defense also felt that advice from a select group of key women in their respective fields on internal policies or problems would be of value.

The Defense Advisory Committee on Women in the Services (DACOWITS) was therefore established and has been in existence for approximately six years. It is composed of approximately fifty women leaders selected to give wide distribution in fields of interest and in geographical representation. Members are appointed by the Secretary of Defense and normally serve for a period of three years. The committee meets in Washington twice a year. Last spring the new members were taken on a field trip to installations where training programs for women are conducted.

It was my privilege as a newly appointed member, along with 13 others, to visit four of the installations where women are trained for the WAVES, WACS, MARINES and WAF, as well as the Army and Navy Medical Centers in Washington and Bethesda. It was a rewarding experience for us to see first hand the well organized training that these women all receive. We had an opportunity to visit many of the classes at Bainbridge, Maryland, where WAVES are trained; at Parris Island, South Carolina Training Center for Women Marines; at Lackland Air Force Base in Texas where women in the Air Force are trained; at Fort McClellan, Alabama, the training center for WAC personnel. In all of the services women attend schools with their male counterparts for technical training while basic training units are separate. There are many career opportunities for women in all of the services.

The functions of DACOWITS are two-fold—interpretative and consultative. As an interpretive body it is the purpose of the committee to create public acceptance of military service for women, both as a career opportunity and as a citizenship responsibility. To accomplish this mission the entire committee is divided into five working groups or sub-committees. They are: education, medical services; citizenship and intergroup relations; organizations and informational services.

It is my privilege to serve as a member of the working group on medical services. This group is interested in projects to enhance the prestige of nurses, dietitians, occupational therapists, physical therapists and such other related personnel as may be required by the armed services.

The sub-committee on medical services has to date concerned itself primarily with the acute shortage of nurses and devoted a considerable amount of time to assisting in the recruitment of nurses for the Army, Navy and Air Force as well as to the study of methods whereby these numbers could be increased to provide adequate nursing care in the service hospitals. One of the results has been the army student nurse program.

In a consultant capacity committee members function, individually or collectively, as consultants on internal policies or problems concerning women in the services when and as requested.

Such matters as more effective utilization of women, expansion of opportunities, training, housing, educational and recreational standards have been the concern of the entire committee.

Committee members also work with the direc-

tors through the executive secretary, and officers stationed in the Department of Defense. The directors represent the WAC (Women's Army Corps), WAF (Women in the Air Force), WAVES (Women in the Navy), Women Marines (Women in the Marine Corps), Army Nurse Corps, Navy Nurse Corps, Air Force Nurse Corps, Army Medical Specialist Corps and the Air Force Medical Specialist Corps.

In the Army, Navy and Air Force there continues to be an acute shortage of occupational therapists and dietitians. The commissioning of occupational therapy students from approved schools in their clinical training year by the Army, Navy and Air Force has helped to provide some additional personnel, but it has not met the most important need—that of therapists with some professional experience. There is a great opportunity for therapists with civilian experience, who meet the qualifications, to broaden their professional knowledge by serving in one of these branches.

The representation of occupational therapy on this important committee should prove to be an advantage for both the committee and the profession.

H. Elizabeth Messick, O.T.R.

From the Educational Secretary

It is with pleasure that the education office announces the names of those examinees who successfully completed the June, 1956, registration examination.

Adams, Lynn F.
Ain, Myrna L.
Alden, Margaret
Allen, Barbara L.
Allen, Frank
Allen, Mary A.
Amino, Yoshimi
An, Annie
Anderson, Janet M.
Anderson, Marlys J.
Austin, Shirley A.
Barr, Lucy A.
Bair, Roy E.
Barber, Elizabeth W.
Barrett, Betty H.
Bartlett, Nancy J.
Bast, Patricia R.
Bates, Anna W.
Beck, Helen L.
Beelen, Jeanette K.
Belue, Bernice A.
Benkelman, Bonnie J.
Benzing, JoAnn E.
Bird, Jane R.
Blaho, George T.
Blunt, Merle K.
Boardman, Jane B.
Born, Barbara A.
Brewster, Harriett E.
Brown, Anna J.
Brown, Betty J.
Brown, Carol L.
Brown, Jean
Brust, Velda J.
Bryce, Theodora E.
Brye, Barbara J.
Burget, Marilynn J.
Burke, Rosa M.
Butler, Jean L.
Butler, Marion M.
Calabresi, Celia G.
Calbom, Margaret A.
Callahan, Elizabeth
Carpenter, Nola J.
Carroll, Geraldine T.
Carswell, Drusilla
Cella, Isabel C.
Chai, Martha M.
Christopoulos, Sarendo
Chung, Eldean S.
Cleveland, Hattye M.
Coe, Arlene M.
Cohen, David
Cohen, Morris
Combs, Carol L.
Conachen, Kayleen J.
Coughenour, Mary L.
Curtis, Marian L.
Daves, Betty B.
De La Charite, Sister Jean
Delaney, Helen F.
Depp, Phyllis C.
De Swarte, Ann E.
Dickinson, Lynne G.
Diehl, Anne E.
Dixson, Gwen A.
Dowd, Carol C.
Dunlop, Laura E.
Dunn, Virginia
Dykhouse, Thelma I.
Eacker, Georgia H.
Eberhardt, Lois J.
Ebert, Roberta M.
Edelman, Mary M.
Edwards*, Barbara C.
Elvin, Faith A.
Engbring, Janet C.
Esau*, Elizabeth
Feinman, Cynthia
Ferguson, Marilynn M.
Figley, Linda K.
Fisher, Patricia M.
Flanner, Nancy R.
Fone, Patricia M.
Foster, Fay J.
Fox, Beverly B.
Fox, Harry E.
Freking, Dorothy L.
Friedmann, Joan C.
Fude, Joanne L.
Gentry, Susan M.
Gill, Jeannette S.
Green, Patricia O.
Green, Patricia W.
Greenberger, Carol H.
Hale, Cynthia S.
Hannah, M. Suzanne
Hansen, Lois A.
Hansen, Patricia J.
Harada, Miyeko
Harper, Archie S.
Harvey, Susan W.
Harwood, Bonna R.
Hasegawa, Emiko A.
Heian, Rhoda A.
Hewitt, Ingrid T.
Hinman, Joan H.
Hirsch, Adrienne C.
Ho, Laura F.
Holder, Joanne S.
Housfeld, Ruth P.
Hudson, Shirley L.
Hultkrans*, Ruth M.
Hunter, Elizabeth A.
Irons, Sally L.
Jackson, Barbara N.
Jacob, Freda
John, Marjorie W.
Johnson, Barbara L.
Johnson, Barbara M.
Johnson, Betty J.
Johnson, Lois E.
Johnston, Barbara G.
Johnston, Margery H.
Jones, Beverly M.
Jones, Marilyn R.
Kedzie, Joanne B.
Kelly, Kathryn J.
Kelsey, Phyllis J.
Keyes, Ruth G.
Kier, Margaret P.
Kirkland, Connie J.
Kirtley, Nancy
Klaus, Elsa L.
Kleinman, Betty
Kneip, JoAnn T.
Knighton, Edith J.
Koch, Marianne E.
Komich, Mary P.
Kong, Su
Kono, Ihoko
Kozeff, Anna
Kraft, Diane E.
Kriewaldt, Marilyn N.
Kroeck, Bennett A.
Kruse, Dorothy A.
Kurosawa, Janice I.
Ladd, Jayne E.
Laguer, Aureo
Lamontagne, Virginia C.
Lanza, Rita G.
Lathrop, Emilie P.
Lawless, Betty J.
Lechnir, Mary J.
Leckie, Mary A.
Lipsitz, Roberta J.
Little, Suzanne M.
Lobenstein, E. Ann
Loder, Mary J.
Lofton, William Jr.
Love, Margaret
Lux, Patricia A.
McGinley, Vivian B.
McGuire, Margaret E.
McKeehan, Marleen
McNearney, Joyce
MacKenzie, Rosanne M.
Magyar, Barbara J.
Marjey, Katherine B.
Mastin, Mary D.
Meissner, Catherine A.
Mendeloff, Sunny K.
Meriwether, Florence D.
Miller, Annette F.
Mitchell, Elizabeth J.
Moore, Traute M.
Morley, Sonya M.
Morrissey, Nancy C.
Mueller, Nancy J.
Muhs, Marjorie M.
Muranaka, Haruko J.
Nakatani, Esther E.
Nash, Marye T.
Neese, Margie L.
Nelson, Margaret S.
Nichols, Betsy J.
Nicolet, Nancy
Nix, F. Joan
Noel, Charlotte L.
North, Mabel L.
Norton, Mary A.
Olson*, Madelyn E.
Osborn, Elinor A.
Osborne, Josephine
Oswald, Dorothy L.
Pahlsson, Ingrid
Pardue, Nancy
Patrick, Donna
Peck, Jean B.
Pepmeier, Erwin H. Jr.
Pifer, Amy
Platt, S. Judith

Pliska, Caroline M.
Poundstone, M. Ellen
Priebe, Judith H.
Quick, Barbara R.
Quillen, Catherine S.
Radike, Ardith J.
Rawhouser, Frances R.
Richards, Dorothy E.
Robertson, Janet E.
Roegner, Rose M.
Rogers, Willena M.
Rottenberg, Rosalyn
Rynders, Nancy D.
Sager, Cecilia J.
Salls, Elizabeth M.
Salter, Elizabeth J.
Sandeen, Anice L.
Sato, Jeanette M.
Schafer, Margaret L.
Schumacher, Nancy J.
Schwartz, Grace R.
Seestedt, Jane E.
Sheehan, Mary H.
Shirey, Paula C.
Silver, Joscelyn L.
Simkin, Sol
Skiles, Nancy D.
Smith, Daniel W.
Smith, Judith A.
Smith, Mae M.
Snyder, Meryl A.
Soholt*, Glady E.
Spencer, Mary J.
Stanson, Betty J.
Stauffer, Nancy C.
Steele, Gwen E.
Stralnic, Gustave G.
Strout, Judith L.
Sutherland, Kathleen C.
Tasker, Ruth M.
Thompson, Helen J.
Thompson, Helen V.
Thorsen, Joan R.
Tilghman, Catherine H.
Toth, Sara
Tripp, Delores J.
Truog, Nancy P.
Umhoefer, Joan M.
Vanstrum, Patricia L.
Vedeler, Karen M.
Wade, Ethelyn A.
Wandling, Helen A.
Watson, Sandra T.
Weber, Catherine C.
Wefald, Karen L.
Whenman, Nancy M.
Wilder, Martha D.
Williams, Elwin L.
Winer, Ruth B.
Woodbury, Gloria B.
Yoshimoto, Lillian S.
Zimmerman, Joan
Zimmerman, Margaret A.
Zucker, Phyllis B.

*Completed with honors.

Mary Frances Heermans, O.T.R.
Educational Secretary

DELEGATES DIVISION

KANSAS

Delegate-Reporter, Clara Dubbs, O.T.R.

"How We Can Help Integrate the Patient Into the Community", was the theme of our three KOTA programs for the year. The first meeting at Topeka State Hospital in November, was a panel with a psychologist, social worker, vocational counselor and occupational therapist from the Topeka area discussing ways occupational therapists could aim for integrating the patient into the community in their daily treatment programs.

In February at Wadsworth V.A. Hospital, we were given valuable material for our ever increasing load of chronic patients, in the lecture, "'The Psychological Effects of Brain Damage." We were oriented as to how much we can expect from this type of patient. A film made by the Kansas Rehabilitation Center for the Blind was shown by a former client of the center. It demonstrated how blind patients are trained to adjust to their blindness and become adequate members of the community.

The group met at the Kansas City Rehabilitation Institute in April and the staff demonstrated how they returned a patient to useful activity in the community by means of an upper extremity prosthesis.

KOTA was well represented by its members at the AOTA conference in San Francisco, the mid-year Board meeting in Detroit and the AHA institute at St. Louis. The Association sponsored the AOTA exhibition at the meeting of the Southwest Clinical Society of Physicians in Kansas City for the second consecutive year. Individual members have participated in numerous recruitment talks, hospital demonstration days and a TV program.

OFFICERS

President .....Genevieve Powell, O.T.R.
Vice-President .....Dorothea Mackenthun, O.T.R.
Secretary .....Mary Ellen Talmage, O.T.R.
Treasurer .....Shirley Lewis, O.T.R.
Delegate .....Clara Dubbs, O.T.R.
Alternate Delegate .....Ellen Roose, O.T.R.

MASSACHUSETTS

Delegate-Reporter, Marion W. Crampton, O.T.R.

One of our association's aims was to acquaint the membership with the structure and function of allied associations as well as our own. A panel made up of nursing, physical therapy and social service spoke on their national professional association's functions, i.e. the over-all structure—qualifications for membership, dues, committees, relationship to local associations, advisory councils; ways of serving the membership; steps taken to establish policies for salaries, hours, vacations and kinds of contacts with other organizations.

For a related program Miss Mary Frances Heermans, AOTA's educational secretary, reviewed the growth and development of the educational program touching on grants, institutes, scholarships and registration examination.

Another aim has been to find ways of stimulating active interest in the association and better attendance at the meetings. Results from a questionnaire, sent to each member, revealed an interest in learning more about research and becoming better acquainted with pre-vocational aspects and a desire for more opportunities for exchange of ideas and discussion.

Since another of our aims has been to serve the membership, the civil service committee prepared a lengthy report for the commissioner of the department of mental health and Barrington Associates, a firm of management consultants, showing why there was a need for change in job specifications and salary upgrading for state psychiatric occupational therapists. The Commonwealth of Massachusetts had hired this firm to make a study of job specifications and salary ranges of practically every state employee.

OFFICERS

President.....Eileen M. O'Hearn, O.T.R.
VicePresident .....Frances E. Carr, O.T.R.
Secretary.....Susan Berquist, O.T.R.
Treasurer.....Joanne C. MacDonald, O.TR.
Delegate .....Marian Crampton, O.T.R.
Alternate-Delegate.....Bruce Fessenden, O.T.R.

NORTHERN NEW ENGLAND

Delegate-Reporter, Sarah H. Thorndike, O.T.R.

Activities of the Northern New England Occupational Therapy Association have been on the quiet side this past year. We hold four all-day meetings yearly, omitting the winter months. They take place at various institutions within the area and have been well attended by members and guests. They are in the form of a field trip and the OT hosts have offered good programs of professional interest with luncheon and time for the business meeting.

Considering our small membership of twenty-one active and ten associate members we are pleased with the

progress of our scholarship fund. For its benefit the whole membership enthusiastically worked towards a financially successful rummage sale and a food sale occurring on a Saturday in early September in Concord, New Hampshire. Concord was chosen because it is one of the largest and most central cities of the three states.

Our newsletter, published four times a year, is mailed out several weeks before the meetings.

OFFICERS

President ..... Patricia L. Calef, O.T.R.
Vice-President ..... Eleanor Kyle, O.T.R.
Secretary ..... Eleanora Chernewski, O.T.R.
Treasurer ..... Lois Marler, O.T.R.
Delegate ..... Sarah H. Thorndike, O.T.R.
Alternate Delegate ..... Ruth MacDonald, O.T.R.

PENNSYLVANIA

Delegate-Reporter, Corinne V. White, O.T.R.

One of the primary aims of the Pennsylvania Occupational Therapy Association during this past year has been to stimulate greater interest and attendance at our meetings in order to promote a more vital organization. To achieve this goal we have planned meetings which were of interest to all the various disability areas whenever this was possible. Also we have put greater emphasis on the social aspect of our meetings, feeling that getting to know each other better will provide greater opportunity to share ideas and experiences in occupational therapy. Another projected effort along these lines is a Pennsylvania Occupational Therapy Association newsletter to come out bi-monthly through the coming year. This periodical will contain information about the coming meetings with a description of the program of the previous meeting. Also this will serve to keep those members living at a distance well informed and up-to-date on current happenings.

Our interest in recruitment has continued during the year with several of our members having given talks on occupational therapy at high school career conferences and women's clubs.

Much time and energy has been expended this year on the problem of additional scholarship funds. To aid with this it was suggested by one of our members that a refresher course in various techniques and media used in occupational therapy or related medical subjects be given. A 10 week (2 hours each week) course in metal enameling and one in activities of daily living were decided upon with several members of the association donating their time as instructors. Twenty-two occupational therapists participated in these courses with $350 being realized for the scholarship fund. This was a successful venture and it is hoped that additional courses may be made available during the coming year.

During the week of October 15-19, the council of the World Federation of Occupational Therapists will be meeting in Philadelphia. The Pennsylvania Occupational Therapy Association is planning to entertain this group at dinner on the 16th of Oct. and we are looking forward to meeting these delegates from ten member nations.

OFFICERS

President ..... Unarda S. Boggs, O.T.R.
Vice-President ..... Genevieve L. Desmond, O.T.R.
Secretary ..... Barbara J. Correll, O.T.R.
Treasurer ..... Elizabeth H. Murphy, O.T.R.
Delegate ..... Corinne V. White, O.T.R.
Alternate Delegate ..... Dorothy Seesholtz, O.T.R.

Examination . . .

(*Continued from page* 287)

therapy school graduate for professional practice.

The registration examination has also stimulated other committees and agencies within the Association to extend their efforts in the development of curriculum guides and evaluation forms to reflect the best possible standards for the academic and clinical preparation of future occupational therapists.

The author wishes to close with a statement of his sincere appreciation to all the occupational therapists who have worked so diligently in the development and continued maintenance of the registration examination. He has never met so dedicated a group who have worked unfailingly for the advancement of the profession. The entire Association owes an enormous debt to these unsung heroes. I know that they and many others will continue their splendid work in the next decade toward developing an examination without compare.

Supervision . . .

(*Continued from page* 292)

consultation and first hand communication are the best tools a supervisor can have. He attempts to understand the individual and groups with whom he must deal and tries to get in step with them. He knows that he will have to reassure people constantly and at the same time maintain his store of energy to off-set the doubters who make up every group. He attempts to satisfy the basic and individual needs of his staff especially their need for security knowing that it is the insecure ones who usually give the trouble. Finally, it may be said that the highest type of supervision is one of democratic leadership, a relationship between the leader and followers which releases the creative ability of individuals and energizes the potentialities of the group.

REFERENCES

American Management Association, *The Foreman's Basic Reading Kit*, American Management Association, 330 West 42nd Street, New York 18, New York, 1944.

Barr, A. S., Burton, W. H., and Brueckner, L. J., *Supervision*, (Second Edition). Appleton-Century, Inc., New York, 1947.

Broaded, Charley, *Essentials of Management for Supervisors*, Harper and Brothers, New York, 1947.

Chase, Stuart, *The Proper Study of Mankind*. Harper and Brothers, New York, 1948.

Dooker, M. Joseph and Marquis, V., Editors, *The Supervisor's Management Guide*. American Management Association, New York, 1949.

Gardner, Burleigh B., *Human Relations in Industry*. Richard D. Irwin, Inc., Chicago, 1947.

Hoslett, Schuyler Dean, Editor, *Human Factors in Management*, Harper and Brothers, New York, 1946.
Kalsem, Palmer J., *Practical Supervision*. McGraw-Hill Book Company, New York, 1945.
Katz, Robert L., "Skills of an Effective Administrator." *Harvard Business Review*, Jan.-Feb. 1955.
Modern Industry, "What it Takes to be a good Executive." Reprinted from *Modern Industry*, August, 1948.
Nahm, Helen, *An Evaluation of Selected Schools of Nursing: With Respect to Certain Educational Objectives*. Stanford University Press, Stanford, California, 1948.
Overstreet, Harry A. and Bonaro W., "Building Sound Human Relationships." *Journal of Industrial Training*, May-June, 1953.
Rice, James O. and Dooher, M. J., Editors, *The Management Leader's Manual*. American Management Association, New York, 1947.
Roethlisberger, Fritz Jules, *Management and Morale*. Harvard University Press, Cambridge, 1941.
Spates, T. G., "Leadership and Human Relations at the Places Where People Work," Reproduced from *Advanced Management*, (Vol. XIII No. 3) Quarterly Journal. The Society for the Advancement of Management, New York 7, New York.
Strang, Ruth, *Counseling Techniques in College and Secondary School*. (Revised and enlarged). Harper and Brothers, New York, 1949.
Tead, Ordway, *The Art of Leadership*. McGraw-Hill Book Company, New York, 1935.
Wiles, Kimball, *Supervision for Better Schools*. Prentice Hall, Inc., New York, 1950.

Motivation . . .

(*Continued from page* 297)

1. Physiological needs
2. Safety needs
3. Love and belonging needs
4. Self-esteem needs
5. Self-actualization needs
6. The desires to know and understand

Maslow writes that "the chief dynamic principle animating this organism is the emergence of less potent needs upon gratification of the more potent ones. The physiological needs when unsatisfied, dominate the organism, pressing all capacities into service and organizing these capacities so that they may be most efficient in this service. Relative gratification submerges them and allows the next higher set of needs in the hierarchy to emerge, dominate, and organize the personality, so that instead of being, e.g., hunger obsessed, it now becomes safety obsessed. The principle is the same for the other sets of needs in the hierarchy, i.e., love, esteem, and self-actualization."[6] However, the organism is dominated and its behavior organized only by satisfied needs; therefore, the satisfied needs exit only in a potential fashion in that they may emerge again to dominate the organism if they are thwarted.[6]

The desire to know and understand appears to be quite important but little is known "about the cognitive impulses, their dynamics, or their pathology."[6] Nonetheless, Maslow "feels certain they exist perhaps as a function of intelligence and of gratification fairly high up the scale of lower-order needs."[7]

We have spoken as though this hierarchy were a fixed order, but it is not nearly so rigid as we may have implied. "It is true that most of the people with whom we have worked have seemed to have these basic needs in about the order that has been indicated. However, there have been a number of exceptions."[6] For instance, "people who have been satisfied in their basic needs throughout their lives, particularly in their earlier years, seem to develop exceptional power to withstand present or future thwarting of these needs simply because they have strong, healthy character structure as a result of basic satisfaction . . . It is just the ones who have loved and been well loved, and who have had many deep friendships who can hold out against hatred, rejection, or persecution."[6] It also seems probable that the most important gratifications come in the first two years of life."[6]

Maslow does not feel that all behavior is motivated. He says there "are many determinants of behavior other than motives . . . Secondly, we may call attention . . . to the concept of degree of closeness to the basic needs or degree of motivation. Some behavior is highly motivated, other behavior is only weakly motivated. Some is not motivated at all (but all behavior is determined)."[6]

SUMMARY

We have discussed some of the major viewpoints on motivation in relation to personality development. However it is not the only determinant and it would be fallacious to assume it is. Most of our behavior seems to develop as a result of the interaction of multiple motivation, environment and a number of other variables. However, motivation is certainly one of the main determinants of personality development.

REFERENCES

1. Adler, A. *The Practice and Theory of Individual Psychology*. New York: Harcourt, Brace and Co., Inc., 1929, pages 1, 7.
2. Freud, S. *Civilization and Its Discontents*. New York: W. W. Norton & Company, Inc., 1930, page 392.
3. Garrett, H. E. *Great Experiments in Psychology*. New York: Appleton-Century-Crofts, Inc., 1951, pages 172, 173, 196.
4. Horney, K. *New Ways in Psychoanalysis*. New York: W. W. Norton and Company, Inc., 1939, pages 8, 9, 75, 76.
5. Hunt, J. McV. *Personality and the Behavior Disorders*. New York: The Ronald Press Company, 1944, page 28.
6. Maslow, A. H. *Motivation and Personality*. New York: Harper & Brothers, 1954, pages 66, 107, 84, 93, 98, 100, 103.
7. McClelland, D. C. *Personality*. New York: The

Dryden Press, 1951, pages 383, 388, 391, 392, 399, 404, 401, 402, 410, 411.
8. McClelland, D. C. *Studies in Motivation.* New York: Appleton-Century-Crofts, Inc., 1955, page 12.

REVIEWS

Cerebral Palsy—Advances in Understanding and Care, Viola E. Cardwell, R. N., P. T., M. A., Association for the Aid of Crippled Children, N. Y., 1956, 625 pp., $5.00.

This book is a good composite of the problems encountered in treating cerebral palsy and the present means of solving them. It gives the medical aspects of the disease—etiology, neuroanatomy, pathology and diagnosis—and then goes into the total habilitation of a cerebral palsied individual. All of the various therapeutic approaches worked out by the leading physicians in the field are explained briefly, and the different treatments now in use are gone into fairly well, including bracing, surgery, drugs, PT, OT, speech therapy and special education. The disorders of cerebral palsy such as those in communication (speech, hearing, vision), in intelligence and perception, in personality development, in social development and problems of employment are discussed as to causes and treatment. Finally, the community aspects of cerebral palsy are considered: how to plan a community program, the extent of the problem, services needed and many of those available in New York State, research being done and needed and methods of prevention of the disease.

Because of the many areas of treatment and service covered by this book, none of the topics are dealt with in great detail, but the main and pertinent facts are presented clearly and concisely. The value of the book lies in its containing under one cover most of the present-day thinking in cerebral palsy. It should make a good reference book for college students or any professional person seeking information on this subject.

—Adaline J. Plank, O.T.R.

APPRAISAL OF PATIENT GOALS IN A COMMUNITY REHABILITATION CENTER, Keith C. Keeler, M.D., *Archives of Physical Medicine and Rehabilitation*, Vol. 37, No. 5, May, 1956.

With the ever increasing public realization for the need of rehabilitation centers and the increasing number of occupational therapists who find themselves in this field, this article is a pertinent one.

It is concerned with a study made by the personnel at the Rehabilitation Center of Summit County Inc., in Akron, Ohio, under the directorship of Dr. Keeler. The purpose of this study was to determine how essential certain non-medical factors are in the prognostication of rehabilitation goals with each individual patient.

For this study, successful rehabilitation goals were considered to be the attainment of functional activities that were not previously performed; the patient was his own standard. The larger economic goals of employment were not considered.

The statistics from the study were based on 139 patients of the general rehabilitation group who were discharged from this center. The entire staff was asked to approve each of these patients independently on the basis of: (1) the success of the patient's rehabilitation, (2) the degree of motivation of the patient, (3) whether or not, in their opinion, the treatment was discontinued at the right time, and (4) whether the patient might have done more than he learned to do.

At the conclusion of this study it was felt that medical goals could be modified by non-medical factors. These non-medical factors consist of: (1) fee payment, (2) age, (3) referral source, (4) type of disability, (5) education or mentality, (6) emotionality, home environment and sociability.

On the basis of this study more accurate prognosis can be made on the rehabilitation of a patient at the time he is admitted to the rehabilitation center. This does not mean that patients who do not meet the optimum standards will be excluded from rehabilitation services, but rather will require more skill on the part of the physiatrist and therapists.

—Elizabeth M. Nachod, Capt., AMSC (OT)

MEDICAL AND PSYCHOLOGICAL TEAMWORK IN THE CARE OF THE CHRONICALLY ILL, edited by Molly Harrower, Ph.D., Charles C. Thomas, 1955.

This book contains reports and discussions of a conference of thirty persons chosen from three disciplines: internal medicine, psychiatry and clinical psychology. They studied the care and problems of the chronically ill, teamwork involved for proper treatment, and the need for proper research and communication.

In addition to the general program which synthesized points of view through discussion, three study groups were formed and made recommendations on: (1) more effective rehabilitation efforts, (2) programs for teaching and training personnel needed, and (3) the complexity of research.

Chauncey D. Leake, one of the conference coordinators, sums up the conference by stating that "the scientific challenge in chronic illness was explored both from the standpoint of psychology and from the basis of definitive medical care. Much emphasis was placed upon the part to be played by the chronically ill patient and groups of such patients in the study and management of chronic illness. Finally, there was significant discussion on various aspects of communication between psychologists, internists and psychiatrists in regard to chronically ill patients, concluding with an important consideration of semantic disciplines in planning a medical and psychological program for the chronically ill."

This reviewer recommends that forward looking occupational therapists locate copies of this book and through reading it and some of the references listed in its bibliography, become familiar with some current thinking and planning in the large and important area of chronic illness. The foreword and concluding notes indicate that occupational therapy representatives were considered for this conference and recommended for future conferences on topics relating to chronic illness. Through keeping abreast, we can stimulate, sharpen and focus our own thinking, direction and action.

—Barbara Locher, O.T.R.

PSYCHIATRY, THE PRESS AND THE PUBLIC: American Psychiatric Association, Washington, D.C., 1956.

A report of a conference on the problems encountered in communicating psychiatric problems to the public. The conference was composed of members from the American Psychiatric Association and representatives from the National Association of Science Writers, journalists and free-lance writers.

The public attitude toward mental illness was analyzed. Although no effort was made to establish a code of conduct, the conference did enable the writers and the psychiatrist to evaluate their particular problems so that there was more mutual understanding.

The book is a well-presented study of a problem that needs to be solved for the education and edification of the public.

THE NURSE AND THE MENTAL PATIENT: A STUDY IN INTERPERSONAL RELATIONS, Morris S. Schwartz, Emmy Lanning Shockley, Russell Sage Foundation, 1956.

This book is very readable and should be a valuable addition for clinical practice students as well as therapists working in psychiatry. Helpful guides are included and stressed for coping with difficult situations in the area of interpersonal relationships. These include such things as careful observations, appraisals of therapeutic efforts and of procedures being used, explorations of alternate ways of working with a patient, and so forth.

The book is divided into two parts. The first part contains discussions of a number of recurring problem situations, focusing on the ways in which the nurse and patient affect each other. Examples of situations covered are fear and patient assaultiveness, the demanding patient, the withdrawn patient, the extremely anxious patient, etc. This section includes a wealth of concrete illustrations drawn primarily from a year of research of "what went on" between staff and patients in a disturbed ward of a small psychiatric hospital.

Part II emphasizes interpersonal processes common to problem situations discussed in Part I. This is accomplished through a fine example of a nurse's participation with a patient that was meaningful and useful to both. Chapters on understanding, communicating with and relating to the patient are also found in this section.

In summary this book does have value in the area of understanding and dealing with many of the problems a nurse or occupational therapist would meet through daily work with patients in a mental hospital.

—Barbara Locher, O.T.R.

REHABILITATION OF THE MENTALLY ILL THROUGH CONTROLLED TRANSITIONAL EMPLOYMENT, Leopold Bellak, M.D., Bertram J. Black, Abraham Lurie, Joseph S. A. Miller, M.D., *American Journal of Orthopsychiatry*, Vol. XXVI, No. 2, April, 1956.

The Altro Health and Rehabilitation Services, located in the Bronx, N. Y. C., has been conducting a rehabilitation program for arrested tuberculous patients and cardiac patients for several years. The program has recently been extended to include psychiatric patients selected from Hillside Hospital, Glen Oaks, N. Y.

One of the basic purposes of the Altro program, the authors explain, "is toward return of the client to as normal a set of living conditions and working productivity as is possible in terms of his capabilities and handicap. The stay at Altro can be looked upon as a form of industrial convalescence."

Industries provided in the workshop program consist chiefly of the single needle power sewing machine, sewing machine repair, preparation for skilled work in the garment trade, and classroom instruction in office and business machine practice.

In addition to the work training environment, services are also offered for psychotherapy, casework interviews, and medical supervision.

—B. Piper, O.T.R.

MEDICAL WRITING, M.D. Publications, Inc., New York, N. Y., 1956, $3.00, 65 pp.

A well-written, easily read symposium of articles by Henry E. Siegerist, M.D., Hans Selye, M.D., Hugh Clegg, M.D., Walter C. Alvarez, M.D., and Felix Marti-Ibanez, M.D. The clarity and quality of the writing make these monographs delightful as well as constructive reading for any author.

PLANNED MANAGEMENT FOR REHABILITATION OF THE THORACIC SURGICAL PATIENT, Elmer J. Shabart, M.D., Wilma-Nell Harmony, B.S., and Earl C. Motta, M.A., *The Physical Therapy Review*, Volume 36, Number 8, August, 1956.

There appears to have been an increase in definitive thoracic surgery during the last five years but little mention has been made of an adjunctive program of rehabilitation. The authors believe that the ancillary services of physical and occupational therapy can offer the thoracic surgical patient the opportunity to minimize deformity and to regain functional ability. A plan, combining the services of the surgeon, nurse, physical and occupational therapist, is functioning successfully at the Veterans Administration Hospital, Livermore, California.

This two-phase program is initiated by the surgeon. The first phase of the program is preoperative and consists of determining the goals for each patient and of orienting him to them.

The second phase is postoperative and is the implementation of the plan. Through graded exercise and proper positioning, the physical therapist assists in restoring the patient to his maximal physical capacity. The ocupational therapist provides the transition from rest habits to functional activity by means of a coordinated, functional, meaningful activity program. The program is designed to maintain postural gains, to further develop the range of motion and to increase endurance.

—Maryelle Dodds, Capt., AMSC (OT)

THE LIBERTY MUTUAL REHABILITATION PROGRAM, W. Scott Allan, *Archives of Physical Medicine and Rehabilitation*, Vol. 37, No. 7, July, 1956.

Over ten years ago Liberty Mutual Insurance Company reviewed a large group of patients to determine their employment status. They found a great need in the period between the end of surgical healing with definitive medical care and return to employment. This resulted in a study of current facilities in the United States and Canada.

Liberty Mutual felt that their function was not just to reduce accident hazards and compensate for injuries, but to reduce lost time and to help the individual become a useful, self supporting citizen. They agreed that to begin centers, specialized for the industrial accident case, might encourage and stimulate interested groups on the local level.

The first center was opened in June, 1943, in Boston and the next in February, 1951, in Chicago to meet the large demands of heavy industry. Each center has qualified orthopedic surgeons on the consulting staff and each patient is given a complete physical examination to determine his status upon entry.

The patient is on a full, daily program which includes physical therapy, recreational therapy and occupational therapy, which is built around a woodworking shop. Nurses, trained in techniques of practical counseling, work with the patient and the employer. Outside agencies are used for aptitude testing or re-training for other work.

Of the 3,616 patients that had been treated by 1955, over 82% actually returned to work, with about one-third returning to different jobs. Average age of both males and females was 44 years and the average time lapse between injury and admission was six months.

Human gain and business gain go hand in hand for a saving of approximately $1,000 per case; this was found in a study of 30 patients treated at the Boston Center. Dramatic savings in workmen's com-

pensation (approx. $20,000) and medical costs (approx. $80,000) were realized when a spinal cord injury was treated. The author expressed the feeling that the value of combined efforts of medicine, industry and insurance companies in the rehabilitation of all potentially serious disability cases had been demonstrated in a practical manner.

Since the centers were set up as pilot studies, there will not be a whole chain of company rehabilitation centers. Instead, the success of these centers may encourage community development of similar centers to which the company may refer patients.

Currently, Liberty Mutual is undertaking establishment of a combined service in conjunction with Boston University School of Medicine and Massachusetts Memorial Hospital. The object is a specialized center to treat spinal cord injuries and to develop research and teaching programs for this specialty. Growth in the company's knowledge of rehabilitation confirms their feeling that it is a problem of many agencies and communities and will be solved with close integration of services.

—Winifred J. Watson, Capt., AMSC (OT)

The following articles, abstracted from the June, 1956, issue of *Physical Medicine and Rehabilitation* (Volume 37, No. 6) were presented at the thirty-third annual session of the American Congress of Physical Medicine and Rehabilitation in Detroit on August 31, 1955. They were presented for the symposium on the contribution of psychiatry to physical medicine and rehabilitation.

The physicians who presented these papers represented both fields—psychiatry and physical medicine. The feeling gained by the reviewer of the following articles is that the services of the psychiatrist are frequently not necessary, but that the responsibility of the physiatrist is to have a better understanding of psychiatry so that he may recognize the symptoms of the emotional upsets which are concomitant with most physical disabilities. He must also be able to recognize that the problems of some patients cannot be dealt with on a superficial level and therefore the psychiatrist must be called upon for the necessary psychiatric treatment. It is at this time that both services must work in very close cooperation for optimum results.

* * *

CONTRIBUTION OF PSYCHIATRY TO PHYSICAL MEDICINE AND REHABILITATION, A. Ray Dawson, M.D., *Arch. of P. M. & R.*, Vol. 37, No. 6, June, 1956.

The emphasis of this article is on the very close relationship to be found between the two sciences—psychiatry and physical medicine and rehabilitation. Seldom is a patient referred to the services of the physiatrist and his team, who has not suffered an emotional upset in some degree. Thus physical medicine is not only dealing with the restoration of mechanical functions, but also with the creation of the desire to function, and the removal of emotional blocks to readjustment.

The author deals with three areas in which psychiatry can contribute to physical medicine and rehabilitation.

The first area is "psychosomatic manifestations in the musculoskeletal system," and in this area it is pointed out that the physiatrists, for the most part, have been too slow in recognizing psychosomatic factors in their patients. With some patients a course of psychotherapy may be necessary, as well as the physical treatment, to prevent a chronic disability.

The second area discussed is "emotional factors in vocational rehabilitation." Again, in this area, the author feels that the physiatrists (and he is one himself) have not availed themselves of the study of the psychic elements which are a necessary consideration in vocational rehabilitation. They must understand emotional conditions, and the mental processes, in order to realize the true meaning of motivation, frustration, anxiety, goal, desire, etcetera. As an example of this misunderstanding, the author feels that too many physiatrists interpret motivation as being a "pushing process." Motivation in terms of treatment, is an element to be studied, first requiring the removal of mental blocks. This is an "internal and very personal matter." Psychiatry has contributed a great deal to vocational readjustment in the area of human drives.

The third and last area discussed by the author is presented from a somewhat different light than the first two. It is the "creation of a healthy working environment" and deals with the physiatrist and his staff, which in turn, of course, has much to do with the patient's acceptance of his treatment. The physiatrist must have a knowledge of psychiatry in order to understand himself and his technical associates, which in turn will better enable him to realize the necessity of adjusting to his patients. He must be able to play a role which will bring him to a better relationship with each patient through an understanding of the emotional factors concerned. He might have to be a good listener with one patient, a firm prodder with another, and even an ignoring bystander with the next patient. The proper atmosphere can set the stage to allow the patient to grow toward health; for "rehabilitation is a growth process leading to physical and emotional well being."

* * *

ROLE OF A PSYCHIATRIST ON A REHABILITATION SERVICE, Saul H. Fisher, M.D. *Arch. of P. M. & R.*, Vol. 37, No. 6, June, 1956.

This article is concerned with the orientation and operation of a psychiatric team assigned to a rehabilitation service of Bellevue Hospital. This project is supported by the departments of psychiatry and of physical medicine and rehabilitation of the New York University College of Medicine.

The patient is first seen by the psychiatrist in the evaluation clinic which is a means of screening patients as possible candidates for rehabilitation.

The psychiatric team has close and frequent contact with the patient, particularly if there appears to be a problem or it is anticipated that there will be a problem with the patient.

For those patients whose problems cannot be dealt with on a superficial level, a complete psychiatric workup is done. When this is complete the findings are reviewed at a meeting of all personnel who have any contact with the patient (nurses, attendants, therapists, doctors, etcetera.) The material is summarized and integrated into the treatment program. Through these conferences, a better understanding of the patient is possible, and in turn a consistent approach and treatment method by all personnel is assured. This close cooperation by all of the staff is continued throughout the treatment program.

* * *

HOW THE PSYCHIATRIST CAN AID THE PHYSIATRIST, William Benham Snow, M.D., *Arch. of P. M. & R.*, Vol. 37, No. 6, June, 1956.

The author, in this article, is not advocating a psychiatrist on every rehabilitation team. Because of the shortage of available psychiatric therapy, this would be impossible, but this should not deprive a patient in a rehabilitation center of efficient treatment.

Today, with the highly specialized phases of medicine, the physician is unable to give the time which enables him to understand the patient's personality, his environment, and the demands of everyday life. He cannot take the time to discuss the fundamental questions concerning the patient and the effect of the disability or illness on his future life.

It is a well known fact that worry on the part of the patient is a contributing factor in hindering maximum benefit in the rehabilitation program. If both the patient and the patient's family are given information regarding the illness or injury which they are able to understand, progress of the patient will be of a more positive nature.

Unless the individual is an unstable person at the onset of his disability, the physiatrist and his staff should be able to cope with the total needs of the patients, both physical and emotional. This is accomplished through the practice of good human relations between physiatrist, therapist and the patient.

However there are, of course, those patients who require the special technics of the psychiatrist and when this is the case, all members of the rehabilitation team must work in close cooperation with the psychiatrist, as he acts as the "pace setter" in the patient's treatment.

In conclusion "The minimum psychiatric treatment necessary would seem to give the optimum result."

* * *

CONTRIBUTION OF PSYCHIATRY TO RESEARCH IN PHYSICAL MEDICINE AND REHABILITATION, John C. Nemiah, M.D., *Arch. of P.M. & R.*, Vol. 37, No. 6, June, 1956.

In this paper the author points out the areas in physical medicine and rehabilitation related to the emotionality of the individual, where research can make a contribution to the field. He states that the factors which he suggests are by no means complete, nor that some research has not already been started in these areas, but that there is a need for continuous research.

As an introduction to this discussion Dr. Nemiah emphasizes that our studies cannot be limited entirely to the effects on the individual, but also the effects this individual has on the society to which he belongs when this physical and emotional crisis occurs. Thus the research team must not only include the psychiatrist, but also other representatives from the behavorial sciences —the psychologist, social worker, sociologist and social psychologist. The goals of such a research team are two-fold: "to add to the basic theory of individual personality structure (especially ego theory) and of the functioning of groups; and to find solutions to the many sociopsychological problems encountered in physical medicine and in rehabilitation programs."

The review of this article will not discuss each point mentioned by the author, but in general they are concerned not only with the individual, but also what might occur in group interaction, the groups being family, employers, employees, fellow workers, community, fellow patients, rehabilitation personnel, etcetera.

In order to make a more complete and conclusive study, the author points out that studies of an employee group should be made before an injury occurs, so that in the event of an injury to one of its members the effect on the group may be observed. Another point which is important in this field is the emotionality of the disabled child. Since the child's personality is still in the process of growth, this presents problems somewhat different from those of the adult group.

This type of research program will require the closest cooperation between the physical medicine team, the psychiatrist and the behavorial scientists.

—Elizabeth M. Nachod, Capt., AMSC (OT)

EXERCISES FOR THE DISABLED HAND: DEAF-MUTE ALPHABET, Frederick L. Aaron, B.S., *The Physical Therapy Review*, Volume 36, Number 8, August, 1956.

Use of the Deaf-Mute Alphabet can provide a valuable addendum to hand exercise for many patients. Assuming the various positions necessary to form the letters requires refined functions of the intrinsic and extrinsic masculature of the hand and forearm. Exercise for specific muscles can be obtained by selecting words which contain letters requiring the desired motion. There is also a functional carry-over of many of the positions into daily self-care activities.

With a copy of the Deaf-Mute Alphabet, these exercises can be done by the patient at home. A desire to gain skill in this method of communication can stimulate the patient so that he will exercise willingly, thereby overcoming a natural apathy to a repeated program of exercise.

—Maryelle Dodds, Capt., AMSC (OT)

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum rate $3.00 *for* 3 *lines; each additional word ten cents. (Average* 56 *spaces per line). Copy deadline first of each month previous to publication.*

POSITIONS AVAILABLE

Occupational therapist for well equipped outpatient center established 1950, offering nursery school, speech, occupational and physical therapy to cerebral palsied children. Beginning salary $3600, more if experienced. Regular increments. Five day week, four week summer vacation, nine day Christmas holiday, sick leave, and social security. Write Miss Virginia Pettit, Director, United Cerebral Palsy of Cincinnati, Inc., 3601 Victory Parkway, Cincinnati 29, Ohio.

Staff position open for registered occupational therapist. Salary open. Pleasant surroundings and working conditions. Contact Dr. C. G. Ingham, Superintendent, Norfolk State Hospital, Norfolk, Nebr.

Occupational therapist to direct a functional OT program in a treatment center. Liberal salary, sick leave, and vacation. Write to George Cousens, San Joaquin Rehab. Center, 548 So. Wilson Way, Stockton, Calif.

Kankakee, Illinois: Wanted OTR with experience for newly established out-patient program. Excellent salary, liberal personnel benefits. Contact Elizabeth L. Jameson, O.T.R., Program Consultant, Illinois Association for the Crippled, 2325 South 11th Ave., Broadview, Illinois.

Joliet, Illinois: needed staff OTR, no experience necessary in an expanding out-patient treatment center. Case load physical disabilities, children and adults. Personnel benefits liberal. Contact Miss Opal Cutler, O.T.R., 1018 Wilcox St., Joliet, Illinois.

Immediate opening for director of occupational therapy department. Salary range $4121 to $7055. Apply Medical Director, Philadelphia Tuberculosis Sanatorium No. 4, Philadelphia 30, Pa.

Want a different field? How about working with Labrador patients, mostly Eskimo, in a Grenfell Mission hospital? Write Grenfell Association, 25 Huntington Avenue, Boston.

Rehabilitation services program needs graduate OT's eligible for later registration. Experience not necessary. Opportunity for professional growth. Excellent starting salary, pension, liberal holidays, vacation and sick leave. Apply for immediate consideration to W. R. Langbauer, Director, Rehabilitation Services, Tuberculosis Hospital, Oak Forest, Illinois.

O.T.R.'s needed. The New York State Department of Mental Hygiene has a dynamic and expanding occupational therapy program which offers opportunities for initiative in active treatment services, participation in research, and experience in student supervision. Tuition available for advanced courses. Good promotional prospects. Beginning salary $4220. Write Virginia Scullin, O.T.R., Director of Occupational Therapy, 217 Lark Street, Albany, New York.

OCCUPATIONAL THERAPIST

Location: Fort Stanton Tuberculosis Sanatorium, Fort Stanton, New Mexico.

Duties and Responsibilities: Under the direction of the Medical Director of Fort Stanton Tuberculosis Sanatorium. Assume the responsibilities of planning and conducting an occupational therapy program for patients in the two State Tuberculosis Sanitoria, located at Socorro and Fort Stanton, New Mexico.

Qualifications: Graduate from an accredited school of occupational therapy, good judgment and initiative and ability to assume responsibilities and to work effectively with high-cultural groups: Anglos, Spanish speaking and Navajos.

Living Accommodations: Excellent living accommodations are available for single persons or for married couples. Costs for housing are: $15.00 to $20.00 for single men, $15.00 per month for single women, $15.00 to $50.00 for married couples, utilities furnished. Meals at hospital dining room may be obtained for approximately $30.00 per month per individual.

Salary: Open—depending upon qualifications and experience.

Interested persons are asked to write directly to:

Mr. Murray Hintz, Director
New Mexico Department of
Public Welfare
Santa Fe, New Mexico.

Registered occupational therapist—staff position—to direct department in new 169 bed accredited tuberculosis hospital. Benefits include paid vacation, sick, and holiday time. Liberal salary with insurance, retirement, and social security programs. Write William L. Mallory, Genesee County Tuberculosis Hospital, 702 Ballenger Rd., Flint, Michigan.

Wanted immediately: Director of occupational therapy and staff occupational therapist for county tuberculosis hospital. Bed capacity 300 adults, 15 children. Opportunity to work both in shop and on ward, and with occupational therapy students. Salary ranges are $360 to $440 for director and $300 to $360 for staff plus laundry. Liberal vacation and retirement, excellent working conditions. Contact Personnel Department, Benjamin Franklin Hospital, Columbus 7, Ohio.

In the New York State Tuberculosis Hospitals occupational therapy is a dynamic part of the patient's rehabilitation program. Therapists are wanted who are interested in maintaining this concept. Positions available at senior and staff level. Beginning salaries $4650 and $4426 respectively. For further details contact: Supervisor of Occupational Therapy, New York State Department of Health, Division of Tuberculosis Control, 84 Holland Ave., Albany 8, New York.

Coastal temperature . . . seventy-nine
Texas climate . . . . . all sunshine
To five thousand "pesos"
For registered person
To teach our Latinos
Their OT diversion

Personnel Officer, Box 592
Harlingen State Tuberculosis Hospital
Harlingen, Texas

Two O.T.R. vacancies. Embreeville State Hospital. Progressive and expanding program in all areas. 900 bed capacity—40 hour week, 13 holidays, 3 weeks vacation. Salary $4121-$5268. Contact Dr. Eleanor K. Wright, Clinical Director, Embreeville State Hospital, Embreeville, Penna.

Senior therapist position available in challenging job planning and supervising occupational therapy program for alcoholic unit in a developing treatment, training and research center. Psychiatric experience essential; initiative and enthusiasm indispensable! For detailed information write to Personnel Director, Harold E. Miller, New Jersey Neuro-Psychiatric Institute, Box 1000, Princeton, New Jersey.

Wanted: Occupational therapist to complete the professional team of an active and dynamic cerebral palsy center. Pleasant, relaxed atmosphere, four weeks vacation, excellent salary, opportunity for individual freedom and initiative. Wrtie to: Edmund S. McLaughlin, Fairfield County Cerebral Palsy Center, 360 Norman Street, Bridgeport, Connecticut.

Staff therapist, registered, experienced pediatrics; excellent potential, research and training center. Write to: City of Hope Medical Center, 1500 E. Duarte Rd., Duarte, Calif.

Excellent opportunity for OTR's interested in rehabilitation of mentally and physically handicapped adults and children, in a new, comprehensive care medical center affiliated with Albert Einstein Medical College. Salary $3750 with N.Y.C. civil service eligibility, 20 days vacation, 5-day week, 12-day sick leave annually. Contact: Judith M. Fuller, OTR Chief, Occupational Therapy, Bronx Municipal Hospital Center, Pelham Parkway, Bronx, N. Y.

Two occupational therapists wanted for full-time positions in private mental hospital. Census 70 pts. Progressive psychiatric program. Address: Heide F. Bernard, Administrator, Hall-Brooke, Greens Farms, Connecticut.

Immediate opening for director of occupational therapy department. Salary open. Pleasant surroundings and working conditions. OT dept. now operating in the New Norfolk State Hospital Administration Building, with spacious quarters, new and modern equipment. Contact Dr. C. G. Ingham, Supt., Norfolk State Hospital, Norfolk, Nebraska.

Immediate opening for staff OTR in crippled children's hospital and expanding comprehensive rehabilitation center treating multiple disabilities. Functional program for children and adults in well equipped department. Employee benefits and salaries in conformance with AOTA recommendations. Apply: Jack E. Pearson, Morris Memorial Hospital and Rehabilitation Center, Milton, W. Va.

Wanted immediately: staff therapist for private psychiatric hospital. Bed capacity, 300 patients. Student affiliation program. Excellent working conditions. Salary open. Maintenance optional. Write: Miss Ruth L. Smiley, O.T.R., The New York Hospital, Westchester Division, 121 Westchester Avenue, White Plains, N. Y.

Occupational therapist to develop program for emotionally disturbed children in new building 10 miles from Boston. Salary range: $3000 to $3720, civil service benefits. Write: Miss Helen Storr, Head Occupational Therapist, Metropolitan State Hospital, Waltham 54, Massachusetts.

Good opening for an occupational therapist who is capable of organizing the occupational therapy services in a new admission and intensive treatment unit. Dynamic rehabilitation program requires candidate with good potential for teaching and supervising other occupational therapists, students and affiliates. Available to graduates of approved schools with two years experience. Salary $4740.00. Apply to William F. Green, M.D., Fairfield State Hospital, Newtown, Connecticut.

Challenging position of section chief immediately available to registered OT, male or female, in progressive psychiatric hospital located 40 miles south of Kansas City. Require person with knowledge of human dynamics and experience in administering therapy to mentally ill patients. To function as a member of the psychiatric team and responsible for coordinating program including occupational, recreational, musical, and industrial therapies. Holiday, vacation, and sick leave benefits, maintenance available, semi-annual salary increases. Salaries $3888-$4980. Write to Robert O. Perry, Coordinator of Adjunctive Therapies, Osawatomie State Hospital, Osawatomie, Kansas.

Director of occupational therapy department of well established regional rehabilitation center is desired. Applicant must be registered OT with adequate background of rehabilitation experience, capable of building an expanding department in a new rehabilitation center building now under construction. Comprehensive regional aspect of program affords ample opportunity for research in development of such programs in urban areas. For further information contact: Bryce W. Nichols, Executive Director, Cincinnati Goodwill Industries Rehabilitation Center, 304 West Court Street, Cincinnati 2, Ohio.

Occupational therapist for 700 bed hospital to work primarily in the psychiatric section. Good salary, automatic increases, sick leave and vacation and retirement program. Contact H. J. Bearzy, M.D., Director, Department of Physical Medicine and Rehabilitation, Miami Valley Hospital, Dayton 9, Ohio.

Senior Occupational Therapist: for progressive program in fully approved, non-sectarian, acute, general hospital. Our program includes functional and diversional therapy for pediatric and adult patients. Expansion program now underway will offer opportunity for work in rehabilitation unit. A minimum of one year's experience preferred. Liberal personnel policies. Salary open and commensurate with experience. Apply to Personnel Director, Mount Sinai Hospital, 1800 East 105th Street, Cleveland, Ohio.

Interesting research position available for staff therapist in 684-bed general hospital with student affiliation program and active teaching program for medical students and student nurses. 5 day week, 4 weeks vacation, free laundry. Salary $3484. Write to: E. Mazur, OTR, O.T. Dept. F-1863, New York Hospital, 525 E. 68th St., N. Y. 21, N. Y.

Two occupational therapy positions available in demonstrative research project approved by OVR to provide comprehensive regional rehabilitation services. For information please contact: Bryce W. Nichols, Executive Director, Cincinnati Goodwill Industries Rehabilitation Center, 304 West Court Street, Cincinnati 2, Ohio.

Elmhurst, Illinois: Wanted OTR for county wide treatment center. Challenging opportunity, excellent working conditions, liberal personnel benefits. Case load varied physical disabilities, children and adults. Contact Mrs. Florence Goold, O.T.R., 5604 Middaugh St., Downers Grove, Illinois.

Wanted—registered occupational therapist for a 340 bed general hospital. Particular assignment will be a 25 bed psychiatric department. Salary open. Write to the Administrator of the Mobile Infirmary Association, P.O. Box 4097, Mobile, Alabama.

Rockford, Illinois: OTR needed on staff of out-patient treatment center. Experience not necessary, but acceptable. Case load varied physical disabilities, children and adults. Generous personnel benefits. Contact Elizabeth L. Jameson, O.T.R., Program Consultant, Illinois Assoc. for the Crippled, 2325 South 11th Ave., Broadview, Illinois.

Wanted: Registered occupational therapist to head department. Opportunity to use new ideas. For further information contact Jack A. Wolford, M.D., Superintendent, Hastings State Hospital, Ingleside, Nebraska.

Staff therapist for 500-bed teaching hospital: salary $3456-$4320, annual and sick leave, paid vacations and other benefits. Write Personnel Office, University of Virginia, Charlottesville, Virginia.

Registered occupational therapist with experience to direct therapy in medical research hospital. Five day, forty hour week. Salary open—commensurate with experience. Apply Miss Jeanne Meskill, Personnel Department, Rockefeller Institute for Medical Research, 66th St. & York Avenue, New York City, New York.

Occupational therapists (staff) interested in working in New York State contact Mr. Jay Schleichkorn, Director of Clinical Services, United Cerebral Palsy Associations of New York State, 1475 Broadway, N.Y.C. 36.

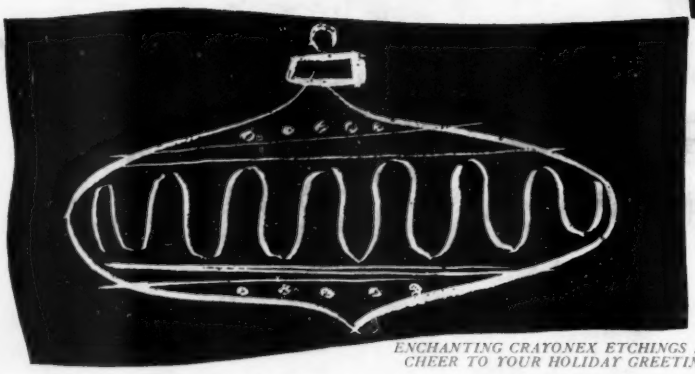
alive today! ... *like 400,000 other Americans cured of cancer who went to their doctors in time*

Let's give our doctors a chance. Thousands of Americans are being cured of cancer every year. But too many are losing their lives needlessly because they failed to consult their doctors when the disease was in its early ... and therefore more curable ... stage.

Form the life-saving habit of a head-to-toe physical checkup once a year. For men, this should include a chest x-ray; for women, a pelvic examination. Make it a habit ... for *life.*

American Cancer Society

CAPTURE THE CHARM OF CHRISTMAS IN YOUR ROOM DECORATIONS WITH POSTER PASTELLO



ENCHANTING CRAYONEX ETCHINGS ADD CHEER TO YOUR HOLIDAY GREETINGS

• TAKE TIME FOR A REAL INSPIRATIONAL CHRISTMAS THIS YEAR!

Rediscover the thrill of achievement as thousands have in creating and decorating their very own Christmas gifts and remembrances.

The makers of Prang Color Products are proud to provide stimulating materials for this enthusiastic return to a more Creative Christmastide!

HOLIDAY CANDLES AGLOW AND GLITTER WITH PRANG DEK-ALL COLORS

CHRISTMAS WRAPPING PAPERS TASTEFULLY DECORATED WITH PRANG WATER COLORS AND TEMPERA

THE AMERICAN CRAYON COM
SANDUSKY OHIO NEW